TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

Authority: A.R.S. § 20-101 et seq.

20 A.A.C. 6, consisting of R20-6-101 through R20-6-159, R20-6-201 through R20-6-218, R20-6-301 through R20-6-308, R20-6-401 through R20-6-409, R20-6-501, R20-6-601 through R20-6-607, R20-6-701 through R20-6-709, R20-6-801 through R20-6-802, R20-6-901, R20-6-1001 through R20-6-1016, R20-6-1101 through R20-6-1120, R20-6-1201 through R20-6-1205, R20-6-1401 through R20-6-1408, R20-6-1601 through R20-6-1607, and R20-6-1701 through R20-6-1704 recodified from 4 A.A.C. 14, consisting of R4-14-101 through R4-14-159, R4-14-201 through R4-14-218, R4-14-301 through R4-14-308, R4-14-401 through R4-14-409, R4-14-501, R4-14-601 through R4-14-607, R4-14-701 through R4-14-709, R4-14-801 through R4-14-802, R4-14-901, R4-14-1001 through R4-14-1016, R4-14-1101 through R4-14-1120, R4-14-1201 through R4-14-1205, R4-14-1401 through R4-14-1408,R4-14-1601 through R4-14-1607, and R4-14-1701 through R4-14-1704, pursuant to R1-1-102 (Supp. 95-1).

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Article 10, consisting of Sections R4-14-1001 through R4-14-1016 and Appendices A through C, adopted effective August 10, 1992 (Supp. 92-2). R20-6-1001 through R20-6-1016 recodified from R4-14-1001 through R4-14-1016 (Supp. 95-1).

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Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted again by emergency effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted by emergency effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). R20-6-1101 through R20-6-1120 recodified from R4-14-1101 through R4-14-1120 (Supp. 95-1).

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ARTICLE 14. INSURANCE HOLDING COMPANY

Article 14, consisting of Sections R4-14-1401 through R4-14-1408 and Appendices A through E, adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 through R20-6-1408 recodified from R4-14-1401 through R4-14-1408 (Supp. 95-1).

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Article 17, consisting of Sections R4-14-1701 through R4-14-1704, adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 through R20-6-1704 recodified from R4-14-1701 through R4-14-1704 (Supp. 95-1).

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Article 21, consisting of R20-6-2101 through R20-6-2104, made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

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ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

R20-6-101. Scope of Article; Definitions

A. Scope. This Article and Title 20 of the Arizona Revised Statutes govern contested cases before the Department. Except as otherwise provided in R20-6-160 for rulemaking petitions, this

Article does not apply to rulemaking or investigative proceedings before the Department. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to contested cases.

B. Definitions. In this Article, the following definitions apply:
1. "Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants or special agents.
2. "Contested case" means any proceeding in which the legal rights, duties or privileges of a party are required by law to be determined by the Director after an opportunity for hearing.
3. "Department" means the Arizona Department of Insurance.
4. "Hearing Officer" means a person appointed by the Director to hear a contested case and make recommendations.
5. "Party" has the meaning prescribed in A.R.S. § 41-1001(12).
6. "Person" has the meaning prescribed in A.R.S. § 41-1001(13).
7. "Director" means the Director of the Department or a hearing officer or any deputy, assistant or examiner of the Director acting in the Director's name in accordance with A.R.S. § 20-150.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-101 recodified from R4-14-101 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1).

R20-6-102. Appearance and Practice before the Director

A. Any person may appear in his own behalf or through counsel. An insurer may appear through legal counsel or through a duly authorized officer of the corporation.

B. When an attorney other than the Attorney General appears or intends to appear before the Director, he shall promptly advise the Director of his name, address and telephone number and the name and address of the person on whose behalf he intends to appear.

C. Conduct at any hearing which, in the discretion of the Director, is deemed contemptuous shall be grounds for exclusion from the hearing. Contemptuous conduct shall include willful noncompliance with an order of the Director or hearing officer, willful disruption or obstruction of any hearing, or any other willful conduct during any hearing which lessens the dignity or authority of the Director or hearing officer.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-102 recodified from R4-14-102 (Supp. 95-1).

R20-6-103. Filing; Service

A. No paper shall be deemed filed until received by the Director.

B. Unless otherwise provided by these rules, copies of all papers filed shall, at or before the time of filing, be served on the hearing officer, the Attorney General, and all parties to the proceeding.

C. Whenever under these rules service is required or permitted to be made upon a party represented by an attorney, the service shall be made upon the attorney.

D. Service upon the attorney, or upon a party, shall be made personally in accordance with Rule 5(c) of the Arizona Rules of Civil Procedure, or by mail by enclosing a copy thereof in a sealed envelope and depositing same, postage prepaid, in the United States mail, addressed to the party to be served or his attorney at the address as shown by the records of the Director. Service by mail is complete upon deposit in the United States Mail.

E. All notices of hearing and final decisions issued by the Director shall be served by mail.

F. Proof of service shall be made by filing with the Director a written statement that service was made.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-103 recodified from R4-14-103 (Supp. 95-1).

R20-6-104. Form of All Filings; Signature

A. All papers filed with the Director shall be typewritten on 8 1/2 x 11 inch paper.

B. Every paper filed with the Director under these rules shall be signed by the party filing it or by at least one attorney, in his individual name, who represents the party. The signature constitutes a certificate by the signer that he has read the paper, that to the best of his knowledge, information and belief, it is well grounded in fact and is warranted by law, and that it is not interposed for delay.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1).

R20-6-105. Amendments

Except where otherwise provided by law or these rules, the Director may amend any notice of hearing or prior order issued by the Director or permit the amendment of any answer in the interest of justice.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1).

R20-6-106. Answer to Notice of Hearing

A. In any notice of hearing, the Director may require that one or more parties shall file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party may file such an answer.

B. Except where a different period is provided by the notice of hearing, a party directed to file a written answer shall do so within 20 days after issuance of the notice of hearing. Where amendments to the assertions contained in the notice of hearing are made subsequent to service of the notice of hearing, one or more of the parties may be required to answer within a reasonable time the amended assertions.

C. Unless otherwise directed by the Director, an answer filed under this rule shall briefly state the party's position or defense to the proceeding and shall specifically admit or deny each of the assertions contained in the notice of hearing. If the answering party is without or is unable to reasonably obtain knowledge or information sufficient to form a belief as to the truth of an assertion, he shall so state, which shall have the effect of a denial. Any assertion not denied shall be deemed to be admitted. When answering party intends in good faith to deny only a part of an assertion, he shall specify so much of it as is true and shall deny only the remainder.

D. If a party fails to file an answer required by the Director within the time provided, such person shall be deemed in default and the proceeding may be determined against him by the Director and one or more of the assertions contained in the notice of hearing may be deemed to be admitted.

E. Any defenses not raised in the answer shall be deemed to be waived.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-106 recodified from R4-14-106 (Supp. 95-1).

R20-6-107. Prehearing Disclosure of Documents and Statements

A. The Director, upon written request, shall allow any party to have a reasonable opportunity to inspect and copy, at the party's expense, admissible documentary evidence or documents reasonably calculated to lead to admissible evidence prior to a hearing in a contested case, so long as such evidence is not privileged. The inspection shall be at the Department or at a place designated by the Director.

B. The Director may order a party to allow the Attorney General or the Department's investigator to have an opportunity, prior to a hearing, to inspect and copy at the state's expense, admissible documentary evidence or documents reasonably calculated to lead to admissible evidence. The inspection shall be at the premises of the party, if located in the state of Arizona. Otherwise, the Director may order the party to produce documents at a place designated by the Director.

C. The Director, upon request by the Attorney General or any party, may require, prior to a hearing, the disclosure of documentary evidence intended to be used at the hearing, so long as such evidence is not privileged. Disclosure may include inspection and copying.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1).

R20-6-108. Subpoenas

A. Any party desiring the issuance of a subpoena to compel the appearance of a witness or the production of documents at any hearing shall file a written ex part application therefore setting forth the name and address of the witness, time and place of appearance, and any documents or tangible things sought to be produced. Upon receipt, the Director shall issue the subpoena.

B. The party requesting the subpoena shall arrange for service of the subpoena as in civil actions. Subpoenas issued at the request of the Director may be served by an employee of the Department or any attorney or agent of the Attorney General's Office.

C. A party may request issuance of an amended subpoena, which shall be served as provided in subsection (B).

D. The person to whom the subpoena is directed may, within 10 days after the service thereof or on or before the return date if the return date is less than 10 days after service, serve upon the Director, the hearing officer and the attorney or party designated in the subpoena, written objection to the appearance or to the inspection or copying of any or all of the designated material. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials except pursuant to an order of the Director. The party serving the subpoena shall have five days within which to file a written response to the objection. The Director's order on the objection shall be based upon the written objection and response. No oral argument shall be heard on the objection unless the Director or hearing officer directs.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1).

R20-6-109. Depositions

A. Except as provided by this Section and otherwise provided by law, depositions may not be taken of any witness.

B. Depositions for use as evidence may be taken of witnesses who cannot be subpoenaed or are otherwise unable to attend the hearing. In order to take a deposition, a party shall file with the Department a written motion with copies to all parties and the Attorney General setting forth the name and address of the witness, the subject matter of the deposition, the documents, if any, sought to be produced, the time and place proposed for the deposition, and the justification for the deposition.

C. If a deposition is permitted, a subpoena and a written order shall be issued. The subpoena and order shall identify the person to be deposed, the scope of testimony to be taken, the documents, if any, to be produced, and the time and place of the deposition. The party requesting the deposition shall arrange for service of the subpoena and order. The subpoena and order shall be served on all parties and the Attorney General five business days before the time fixed for taking the deposition unless, for good cause shown, such time is shortened by the Director or a hearing officer.

D. If the parties agree in writing, a deposition may be taken of a witness for any purpose, in the manner and upon the terms designated by them, subject to approval by the Director or the hearing officer.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1).

R20-6-110. Prehearing Conference

The Director, upon written request of a party or the Attorney General, or on his own motion, and upon written notice to all parties, may direct that a prehearing conference be held for the purpose of clarifying or limiting the procedural, legal or factual issues involved in a contested case.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1).

R20-6-111. Hearings

A. Hearings may be presided over by a hearing officer designated by the Director. All such hearings shall be open to the public, except as provided in A.R.S. § 20-164. A hearing officer appointed by the Director may make all determinations and enter all orders and process which the Director is authorized to make or issue under these rules or any other order necessary for the orderly conduct of the hearing.

B. Any challenge of the hearing officer shall be made in the form of a written motion specifying the grounds for disqualification of the hearing officer and shall be served as soon as practicable under the circumstances, but no later than 15 days after the person discovers that such grounds exist or should have discovered with reasonable diligence. The Director shall rule upon the challenge prior to the commencement or continuation of the hearing.

C. The hearing officer shall regulate the course of the hearing in an impartial manner and shall rule upon procedural and evidentiary matters incidental thereto. The hearing officer may question witnesses. Upon motion of any party, a witness may be excluded from the hearing by the hearing officer prior to his or her testimony, except that this rule shall not be used to exclude a party to the proceeding.

D. All motions and objections made during the course of a hearing shall be made to the hearing officer who shall rule thereon or take them under advisement for later determination. Objections to the admission or exclusion of evidence shall be made on the record and shall state the grounds of objections relied upon.

E. The hearing proceedings shall be stenographically reported by a certified court reporter or mechanically recorded under the direction of a hearing officer who shall retain control of the used reel or tape following conclusion of the hearing.

F. By order of the Director or the hearing officer, proceedings involving a common question of fact or a common respondent

may be consolidated for hearing of any or all of the matters at issue where such consolidation may tend to facilitate a just and efficient resolution.

G. At the discretion of the Director, the hearing record may be held open for a reasonable period of time at the conclusion of the hearing to permit the presentation of additional written arguments, memoranda, evidence or responsive pleadings. At the close of such period, the hearing record shall close.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-111 recodified from R4-14-111 (Supp. 95-1).

R20-6-112. Order of Presentation

All witnesses at a hearing shall testify under oath or affirmation. The parties may make an opening and closing statement. In matters brought at the request of the Director, evidence in support of the Director's action shall be presented first, then the respondent may present evidence in support of his or her position, and then there may be rebuttal and surrebuttal evidence presented. In matters brought at the request of a person other than the Director, including requests for hearing on the denial of a license and other hearings brought pursuant to A.R.S. § 20-161(B), the person seeking the hearing shall present his or her evidence first. The parties may present evidence and conduct cross-examination. The hearing officer shall rule upon the admissibility of evidence sua sponte or upon objection of any party.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-112 recodified from R4-14-112 (Supp. 95-1).

R20-6-113. Computation of Time; Continuances and Extensions of Time

A. In computing any period of time prescribed or allowed by these rules, by order of the Director or by any applicable statute, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included unless it is a Saturday or Sunday or a legal holiday in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

B. Except as otherwise provided by law, the Director or hearing officer, for good cause, may extend time limits prescribed by these rules except those time limits imposed by R20-6-114.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1).

R20-6-114. Request for Rehearing or Review

A. Within 30 days after service of the Director's order on the hearing, any aggrieved party may request a rehearing or review of the order. The request shall be in writing and shall be served upon the Director as provided by R20-6-103, and a copy shall be served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the request.

B. A request for rehearing or review shall be based upon one or more of the following grounds which have materially affected the rights of a party:

1. Irregularity in the hearing proceedings, or any order or abuse of discretion whereby the party seeking rehearing or review was deprived of a fair hearing;
2. Misconduct by the Director, the hearing officer or any party to the hearing;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not have been discovered with reasonable diligence and produced at the hearing;
5. Excessive or insufficient sanctions or penalties imposed;
6. Error in the admission or rejection of evidence, or errors of law occurring at the hearing or during the course of the hearing;
7. Bias or prejudice of the Director or hearing officer;
8. That the order, decision, or findings of fact are not justified by the evidence or are contrary to law.

C. A request for rehearing or review shall specify which of the grounds listed in subsection (B) it is based upon and shall set forth specific facts and laws in support of the request. A request may cite relevant portions of testimony from the hearing by referring to the pages or lines of the reporter's transcript of the hearing and may cite hearing exhibits by reference to the exhibit number.

D. A request for rehearing shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order. A request for rehearing or review may seek multiple forms of relief in the alternative.

E. When a request for rehearing is based upon affidavits, they shall be attached to and filed with the request unless leave for later filing of affidavits is granted by the Director or hearing officer. Leave may be granted ex parte.

F. A request for rehearing or review of the Director's order on the hearing which is not timely made is deemed waived for the purpose of judicial review. A party who fails to request rehearing or review of the Director's order on the hearing shall be barred from raising a claim in any proceeding in which the Director, the hearing officer or the Department of Insurance is a party, except as otherwise required by law.

G. A party may file a written request for a stay of the Director's decision. An order entered by the Director shall not be stayed by the filing of a stay request or a request for rehearing or review. The Director may stay an order pending the resolution of a request for rehearing or review or when justice requires.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-114 recodified from R4-14-114 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-115. Response to Request for Rehearing

A. Each party served with a request for rehearing pursuant to R20-6-114 shall be permitted to file a response within 15 days after the request for rehearing has been filed. This response shall be designated as a "response to request for rehearing or review" and shall be in writing. Affidavits may be attached to and filed with the response. If not filed in this manner, an affidavit shall be filed only if leave for later filing of affidavits is granted by the hearing officer or Director. Leave may be granted ex parte. The original response shall be filed with the Department as provided in R20-6-103, and one copy shall be served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the response.

B. The hearing officer or Director has the discretion to convene a hearing or hear oral argument to consider a request for rehearing.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-115 recodified from R4-14-115 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-116. Reserved through R20-6-158. Reserved

R20-6-159. Repealed

Historical Note
Adopted effective February 17, 1977 (Supp. 77-1). R20-6-159 recodified from R4-14-159 (Supp. 95-1). Repealed effective June 15, 1998 (Supp. 98-2).

R20-6-160. Rulemaking Petition

A. The following definitions apply in this Section.
1. "Department" means the Arizona Department of Insurance.
2. "Director" means the Director of the Department of Insurance.
3. "Petitioner" means a person who petitions the Department for rulemaking action.
4. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.

B. Any person may petition the Department under A.R.S. § 41-1033 for rulemaking action.

C. A person who seeks rulemaking action shall file, with the Director, a petition with the following information:
1. The petitioner's name, address, and telephone number;
2. The name and address of any organization the petitioner represents;
3. A statement of the rulemaking action the petitioner seeks, including:
   a. A citation to any existing rule, substantive policy statement, or Department practice to be amended or repealed; and
   b. The specific language of a proposed new rule or rule amendment;
4. The reasons for the rulemaking action, including an explanation of why an existing rule, substantive policy statement, or Department practice is inadequate, unreasonable, unduly burdensome, or unlawful; and
5. The petitioner's dated signature.

D. The petitioner may submit additional supporting information, including:
1. Statistical data; and
2. A list of other persons and entities likely to be affected by the proposed rulemaking action, with an explanation of the likely effects.

E. Within 60 days of the date the Department receives the petition, the Department shall send the petitioner a written decision indicating whether the Department is denying the petition or will initiate the requested rulemaking action, with the reasons for the decision.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1).

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of Disability Insurance

A. Definitions
1. "An advertisement" for the purpose of these rules shall include:
   a. Printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio and TV scripts, billboards and similar displays; and
   b. Descriptive literature and sales aids of all kinds issued by an insurer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and
   c. Prepared sales talks, presentations and material for use by agents and brokers, and representations made by agents and brokers in accordance therewith.
2. "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides disability benefits, or medical, surgical or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts.
3. "Insurer" for the purpose of these rules shall include any individual, agent, broker, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

B. Advertisements in general. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

C. Advertisements of benefits payable, losses covered or premiums payable
1. Deceptive words, phrases or illustrations – Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered or premium payable. An advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.
   a. Explanation:
      i. The words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy but may be used only in such manner as fairly to describe such benefit.
      ii. A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.
      iii. The benefits of a policy which pays varying amounts for the same loss occurring under different conditions or which pays benefits only when a loss occurs under certain conditions shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.
      iv. Phrases such as "this policy pays $1,800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.
2. Exceptions, reductions and limitations – When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is pay-

able, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

a. Explanation:

i. The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

ii. The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

iii. The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

iv. Waiting, elimination, probationary or similar periods – When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement covered by (C)(2) shall disclose the existence of such periods.

3. Pre-existing conditions

a. An advertisement covered by (C)(2) shall disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

b. When a policy does not cover losses traceable to preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This limits the use of the phrase "no medical examination required" and phrases of similar import.

D. Necessity for disclosing policy provisions relating to renewability, cancellability and termination – An advertisement which refers to renewability, cancellation or termination of a policy, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

E. Method of disclosure of required information – All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

F. Testimonials – Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement including such statements is subject to all of the provisions of these rules.

G. Use of statistics – An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

H. Inspection of policy – An offer in an advertisement of free inspection of a policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement.

I. Identification of plan or number of policies

1. When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

2. When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

J. Disparaging comparisons and statements – An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services or business methods.

K. Jurisdictional licensing

1. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

2. Such advertisements by direct mail insurers shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of some language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."

L. Identity of insurer – The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

M. Group or quasi-group implications – An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

N. Introductory, initial or special offers – An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.

O. Approval or endorsement by third parties

1. An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency, unless such is the fact.

2. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organization, unless such is the fact.

P. Service facilities – An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

Q. Statements about an insurer – An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance business.

R. Special enforcement procedures

1. Advertising file – Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of individual policies and typical printed, published or prepared advertisements of blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such advertisements shall be maintained in said file for a period of not less than three years.
2. Certificate of compliance – Each insurer required to file an annual statement, which is now or which hereafter becomes subject to the provisions of this rule, must file with this Department, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied, or were made to comply, in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule.
3. Acknowledgment – It is requested that the chief executive officer of each insurer to which this rule is addressed acknowledge its receipt and indicate its intention to comply therewith.

Historical Note
Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1).

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

A. Authority and purpose – This rule is adopted by the Director of Insurance pursuant to the rulemaking power of A.R.S. § 20-143, subject to the provisions of A.R.S. §§ 41-1001 through 41-1008. It is the purpose of this rule to implement the administration of the Arizona Insurance Code by defining acts and practices which are contrary to or would violate various sections of the Insurance Code, including but not limited to Title 20, Chapter 2, Articles 1, 2, 3 and 6, Chapter 5, Article 1 and Chapter 6, Article 1.

B. Applicability
1. This rule shall apply:
   a. To any insurance company, agent, person, broker, or solicitor, as those terms are defined in the Insurance Code;
   b. To acts and practices in the advertising, promotion, solicitation, negotiation, or effecting the sale of insurance policies;
   c. To such acts and practices, whether they involve the use of language disseminated by means of sales kits, policy jackets or covers, letters, personal presentations, visual aids, or other sales media.
2. This rule shall not apply to group insurance, franchise insurance, or to annuities without life contingencies.

C. Policy
1. Misleading, through omissions, use of irrelevant material, or improper emphasis – The purpose of this rule essentially is to assure the fair disclosure of relevant facts in the sale of life insurance. As used herein, the words "life insurance" shall mean the entire life insurance contract, including all benefits provided therein, and are not intended to be limited to the benefits payable on death. It is also designed to protect purchasers and prospective purchasers of life insurance policies against the use of sales methods which are misleading because of:
   a. Omission of facts fairly describing both the subject matter as a life insurance policy and the benefits obtainable thereunder; or
   b. An undue emphasis upon facts which, however true, are not relevant to the sale of life insurance; or
   c. An undue emphasis upon features which are of incidental or secondary importance to the life insurance aspects of the policy.
2. In considering possible violations, the Department of Insurance will consider as relevant to a proposed sale, statements which are intended to:
   a. Motivate the insured to purchase life insurance; or
   b. Provide an explanation of the benefits provided by the life insurance policy; or
   c. Present a picture of the company's ability to conduct a life insurance business.
3. Specified acts and practices – To assure such fair disclosure and to prevent the use of misleading sales methods, this rule provides advance interpretations as to the specific acts and practices which the Department of Insurance believes constitute a violation of such statutes; provided, however, it is recognized that whether particular conduct comes within the prohibition of such statutory provisions depends on the facts in each case.
4. Acts and practices not specified – Although this rule is intended to cover selected acts and practices which have been of serious concern to the Department of Insurance, this delineation is not a determination that any act of practice not specified herein is in conformance with the statutes. However, this rule will be read as a guide in considering whether any unspecified act or practice is of the kind or character which may be within the prohibitions of the statute and this rule.

D. Prohibited acts and practices
1. References to profits and investments – In accordance with the authority, applicability and policy set out in subsections (A) through (C) above, the following is declared to be a violation of this rule: The use of the word or words "investment," "investment plan," "founders plan," "charter plan," "expansion plan," "profit," "profits," or "profit sharing" in a context or under such circumstances or conditions as to have the capacity and tendency to mislead a purchaser or prospective purchaser to believe that he will receive something other than a life insurance policy, some benefit not provided in the policy, or some benefit not available to other persons of the same class and equal expectation of life. This is not intended to prohibit appropriate presentation of the investment elements of a life insurance policy.
2. Other limitations – In accordance with subsections (A) through (C) above, the acts and practices set out in the following paragraphs are declared to be a violation of this rule in the sale of life insurance when used in a context or done under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser to believe that he will receive, or that it is probable he will receive, something other than a life insurance policy, some benefit not provided in the policy, or some benefit not available to other persons of the same class and equal expectation of life. Each of said paragraphs will, therefore, be construed and applied in accordance with the provisions of this Section.
   a. Using any phrase as the name or title of a life insurance policy which does not include the words "life

insurance," unless accompanied by other language in the same document clearly indicating that the contract referred to is a life insurance policy.

b. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context which would reasonably be understood to interest a prospect in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy.

c. Making any statement which reasonably gives rise to the belief that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by virtue of the purchase of the policy, unless such statement is made with reference to policies of domestic life insurers engaged in a program as set forth in the provisions of A.R.S. § 20-453.

d. Providing a policyholder with any premium receipt book, policy jacket, return envelope, or other printed material containing references to the company's "investment department," "insured investment department," or similar terminology in such a manner as to imply that the policy is sold or issued or is serviced by the investment department of an insurance company.

3. Referenced to special benefits

a. Making any statement which reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless such is specifically provided in the insurance contract. This paragraph has no relation or applicability to policies under which insured persons of one class of risk may receive dividends of a higher rate than persons of another class of risk.

b. Stating that each stockholder is given the right to purchase or allocate a specific number of policies.

c. Stating or implying that only a limited number of persons or limited class of persons will be eligible to buy a particular kind of policy, unless such limitation is related to recognized underwriting practices, or unless such limitation is specifically stated in the policy or rider therefore.

d. Stating that the policyholders who are to act as "centers of influence" for an insurance company in that capacity will share in the company's surplus earnings in some manner not available to other policyholders of the same class.

4. Coupons

a. Stating or implying that the principal amounts payable under the coupons represent interest, earnings, return on investments, a bonus, or anything other than benefits, the cost of which is included in the total premium. To eliminate misunderstanding of the nature of coupons, each policy, bearing coupons, shall, on its face, bear the following words: "The premium above includes an extra premium of $_____ for coupon benefits."

b. Describing premium payments in language which states the payment is a "deposit," unless:

i. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or

ii. The term is used in conjunction with the word "premium" in a manner as to clearly indicate the true character of the payment.

5. References to dividends

a. Providing any illustration or projection of future dividends which is not based on the actual scale being used by the company for the payment of current dividends. Furthermore, such projection or illustration must clearly indicate that the dividends are not guarantees.

b. Using the words "dividends," "cash dividends," "surplus," or similar phrases in such a manner as to state or imply that the payment of dividends is guaranteed or certain to occur.

c. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the earnings of the company.

d. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement is accompanied by an adequate explanation as to:

i. What benefits or coverage would be provided at such time; and

ii. Under which conditions this would occur.

6. Miscellaneous

a. Describing a life insurance policy or premium payments therefor in terms of "units of participation," unless accompanied by other language clearly indicating the references are to a life insurance policy or to premium payments, as the case may be.

b. Using the words "contract," "contract plan," or "plan" in describing a life insurance policy, unless accompanied by other language in the same document clearly indicating the reference is to a life insurance policy.

c. Including in sales kits and prepared sales presentations proposed answers to a prospect's question as to whether life insurance is being sold, which are designed to avoid a clear and unequivocal statement that LIFE INSURANCE IS THE SUBJECT MATTER OF THE SOLICITATION.

d. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without making an explanation of the non-forfeiture benefits.

e. Using a dollar amount in printed material to be shown to a prospective policyholder unless accompanied by language in such material indicating the nature of the figure. (This is intended to prohibit the use of dollar figures not in relation to guaranteed values and properly projected dividend figures. It is intended to prohibit the use of figures showing growth of stock values, or other values not a part of the life insurance contract.)

f. Stating that a policy provides certain features which are not found in any other insurance policies, unless that in fact be true.

g. The making of any statement or implication in regard to an insurance policy that cannot be verified by reference to the policy contract itself, or a specimen copy of the policy being described, or to the company's officially published rate book and dividend illustrations.

h. Stating that life insurance is "loss proof" or "depression proof," but this shall not prohibit statements

that life insurance benefits (other than dividends) are guaranteed by the company regardless of economic conditions.

i. Making any statement that a company makes a profit as a result of policy lapses or surrenders.

j. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience of your company. This is intended to protect policyholders from being misled through presentations as to the probabilities of the policy being sold having the same results as that of other companies which successfully sold similar policies, without a fair disclosure of the fact that many companies have had unfavorable experience.

E. Effective date. The provisions of this rule shall become effective on January 1, 1969.

F. Severability clause. If any provision of this rule is held invalid, such invalidity shall not affect other provisions of this rule which can be given effect without the invalid provision.

G. Company responsibility. Each company will be held responsible for disseminating this information to their representatives and assuring compliance.

Historical Note

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1).

R20-6-203. Repealed

Historical Note

Former General Rule Number 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-203 recodified from R4-14-203 (Supp. 95-1).

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

A. Definitions.

1. "Listed insurer" means an unauthorized insurer who is on the list created by the Director under subsection (C)(1) and A.R.S. § 20-413.
2. "Surplus lines broker" means a person licensed under A.R.S. § 20-411.
3. "Surplus lines insurance" means the type of insurance described in A.R.S. § 20-407.
4. "Unauthorized insurer" means an insurer that does not have a certificate of authority to transact insurance in Arizona.

B. Filing requirements. Unauthorized insurers writing surplus lines insurance in Arizona and surplus line brokers shall comply with the filing requirements of this Section.

C. List of unauthorized insurers.

1. The Director shall create and maintain a list of unauthorized insurers that may write surplus lines insurance in this state under A.R.S. § 20-413. The list shall include the names of unauthorized insurers for which a surplus lines broker has made the filings required by this Section.
2. A listed insurer shall remain on the list until:
   a. The Director removes the insurer from the list under A.R.S. § 20-413 or subsection (H) or (I) below, or
   b. The insurer requests the Director to remove its name from the list, and the Director consents to the request.

D. Placing surplus lines insurance. A surplus lines broker shall restrict all surplus lines business placed by the surplus lines broker to listed insurers. An insurer's removal from the list does not affect the validity of any contract existing at the time of removal.

E. Requirements for Initial Listing of Foreign Unauthorized Insurers and Insurance Exchanges. A surplus lines broker shall file the following documents for a foreign unauthorized insurer:

1. An original or a certified copy of the insurer's certificate of compliance from the supervisory official of the insurer's state of domicile;
2. A current Certificate of Deposit, Capital, and Surplus for Foreign Insurers from the public officials or other persons who have supervision over the insurer in any other state;
3. A certification from the surplus lines broker of the insurer's compliance with the financial requirements of A.R.S. § 20-413;
4. The insurer's most recent report of financial examination, certified by the insurance supervisory official of its state of domicile; and
5. A certified copy of a full size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer as of December 31 of the preceding year.

F. Requirements for Initial Listing of Alien Unauthorized Insurers. A surplus lines broker shall file a certification of the insurer's compliance with the financial requirements of A.R.S. § 20-413. For all alien insurers other than title insurers, the surplus lines broker may rely on the information contained in the most recent N.A.I.C. Financial Review of Alien Insurers as prima facie evidence of the insurer's compliance.

G. Filing Requirements to Maintain Listing. To ensure that a foreign or alien unauthorized insurer remains on the Director's list, a surplus lines broker shall file, before June 1 of each year:

1. A copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer, as of December 31 of the preceding year; and
2. An affidavit, on a form approved by the Director, that meets the requirements of this subsection.
   a. The surplus lines broker and a duly authorized officer of the unauthorized insurer shall sign the affidavit.
   b. The insurer's officer shall state whether there have been any changes in the insurer's name, address, state of domicile, statutory agent, and any material changes in its operations since the insurer's initial qualification for listing or the last annual filing under this subsection. If there have been material changes in operations, the officer shall describe the changes. In this subsection, material changes include a change in any one or a combination of the following:
      i. A director, officer, or controlling person;
      ii. The insurer's holding company or affiliates;
      iii. The insurer's charter documents, including its articles of incorporation, articles of agreement, or by-laws governing its conduct of business;
      iv. The insurer's marketing or administration plans, operations, or agreements with third parties;
      v. Any other matter material to the insurer meeting its obligations to its policyholders; and
      vi. Any other matter that relates to any of the grounds for removal from the list as prescribed in A.R.S. § 20-413.
   c. The insurer's officer shall state whether the insurer is in good standing in all jurisdictions where it conducts insurance business and whether the insurer has been, since the date of initial listing or the last

annual filing under this subsection, or currently is, the subject of any action or order by any regulatory official in any jurisdiction. If the insurer has been or is the subject of a disciplinary action or order, the insurer's officer shall describe the matter in the affidavit and shall attach a copy of any applicable official document. In this subsection, regulatory action or order includes any one or a combination of the following:

i. Denial, suspension, or revocation of a license, permit, or certificate of authority;
ii. A corrective action or operation plan, consent order, memorandum of understanding, or cease and desist order;
iii. Action against the insurer's bond or securities held in trust by a regulatory official; and
iv. Supervision, conservatorship, receivership, or any other form of possession or control by a regulatory official in any jurisdiction.

d. The insurer's officer shall state whether the report of examination, if any, previously filed with the Director under subsection (E)(3) or with a previous annual filing, remains the most current, filed report. If a more recent report of examination exists, the surplus lines broker shall file a copy of the report with the affidavit.

H. Supplemental information; removal. A surplus lines broker and an unauthorized insurer shall provide any additional information the Director requests to determine whether the insurer meets the requirements of A.R.S. § 20-413, or to clarify documents filed under this Section. The Director may remove an insurer from the list if the surplus lines broker or insurer does not submit the requested information within 30 days after the date of a written request for information.

I. Removal for failure to make annual filing. The Director shall remove an unauthorized insurer from the list if a surplus lines broker fails to timely file the documents required by subsection (G). The Director shall not restore the insurer to the list until a surplus lines broker files all applicable documents required under subsections (E) and (F) and the insurer requalifies under A.R.S. § 20-413.

J. Organizations of surplus lines brokers; unauthorized insurer.

1. A surplus lines broker may file records or reports that are subject to examination with any voluntary organization of surplus lines brokers. The Director may examine the records or reports filed with an organization of surplus lines brokers to ascertain compliance with A.R.S. Title 20, Chapter 2, Article 5. An examination performed under this authority shall not preclude examination of records of a surplus lines broker.
2. Nothing in this rule requires that a surplus lines broker become a member of any surplus lines organization to file or to preserve or maintain any affidavit or statement.

Historical Note

Former General Rule Number 71-24; Former Section R4-14-204 repealed, new Section R4-14-204 adopted effective January 1, 1981 (Supp. 80-6). R20-6-204 recodified from R4-14-204 (Supp. 95-1). Amended effective July 14, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 475, effective January 5, 2000 (Supp. 00-1).

R20-6-205. Repealed

Historical Note

Former General Rule Number 71-25; Repealed effective March 19, 1976 (Supp. 76-2). R20-6-205 recodified from R4-14-205 (Supp. 95-1).

R20-6-206. Local or Regional Retaliatory Tax Information

A. Definitions.

1. "Addition to the rate of tax" means the tax rate determined under subsection (E) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state having local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state under A.R.S. § 20-254 or annuities under A.R.S. § 20-254.01 regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01 regardless of whether the insurer is authorized to transact disability insurance in this state.
9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their agents by any:
   a. City, county, or other political subdivision of a foreign country or other state; or
   b. A combination of cities, counties, or other political subdivisions of a foreign country or other state.
10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
12. "Other state" means any state in the United States, the District of Columbia and territories or possessions of the United States but excluding Arizona.
13. "Premium Tax and Fees Report," including the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," means the form prescribed by the Director and filed annually by insurers pursuant to A.R.S. § 20-224.

C. Scope. This rule applies to all foreign, alien, and domestic insurers.

D. Data to be Reported by Domestic Insurers. Each domestic insurer shall file a Survey of Arizona Domestic Insurers as part of its Premium Tax and Fees Report. The Survey shall report the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:

1. Total local or regional taxes paid; and
2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.

E. Computation of Statewide and Foreign Countrywide Additions to the Rate of Tax. For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.

F. Publication of Additions to the Rate of Tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year pursuant to subsection (D). The Department shall publish the information annually, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

G. Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:
1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.

H. Contest of Computation. A foreign or alien insurer subject to this rule may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

I. Application. This rule applies to Premium Tax and Fees Reports filed by all insurers for the calendar year 1998 and all subsequent years.

Historical Note

Former General Rule Number 72-30. Repealed effective February 22, 1993 (Supp. 93-1). R20-6-206 recodified from R4-14-206 (Supp. 95-1). New Section adopted effective December 29, 1995 (Supp. 95-4). Amended effective November 5, 1998 (Supp. 98-4).

R20-6-207. Industrial Insureds

A. Authority – This rule is adopted pursuant to A.R.S. §§ 20-106, 20-143 and 20-401.01 through 20-401.07.

B. Purpose – The purpose of this rule is to implement the legislative intent, as expressed in Chapter 23, Laws of 1972, to regulate and control industrial insureds contracting with unauthorized insurers in this state.

C. Scope – The scope of this rule is A.R.S. Title 20 and the information and returns required by this rule are declared necessary for the protection of residents of this state.

D. Repeal – This rule does not repeal any known prior rule, memorandum, bulletin, directive, or opinion on this subject matter.

E. Definitions – As used in this rule, unless the context otherwise requires:
1. "Director" means the Director of Insurance of the State of Arizona;
2. "Gross premium" means the total premium charged, deducted or allocated including membership fees, assessments, dues and any other consideration for insurance, less premiums returned on account of cancellation or reduction of premium;
3. "Industrial insured" has the meaning of A.R.S. § 20-401.07(B) and all of the qualifying attributes of such subsection. The term includes self-insureds if any risk or exposure or partial risk or exposure is insured by a non-admitted insurer;
4. "Insurer" has the meaning of A.R.S. § 20-106(C);
5. "Reciprocal state" has the meaning of A.R.S. § 20-401;
6. "Transact" has the meaning of A.R.S. § 20-106(A) and the following provisions of subparagraph (a):
   a. Any of the following acts in this state effected by mail or otherwise, by or on behalf of an unauthorized insurer, is deemed to constitute the transaction of an insurance business in this state:
      i. The making of or proposing to make, as an insurer, an insurance contract.
      ii. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.
      iii. The taking or receiving of any application for insurance.
      iv. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof.
      v. The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state.
      vi. Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state. The provisions of this subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer.

vii. The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance.

viii. The transacting or proposing to transact any insurance business in substance equivalent to any provisions as provided in subdivisions (i) to (viii), inclusive, of this Section in a manner designed to evade the laws of this state.

7. "Unauthorized insurer" as used herein means an insurer transacting business in this state who has not qualified for a certificate of authority, approval to operate as a non-admitted insurer, or for a certificate of exemption and filed a tax return and paid the premium taxes made a condition of such qualification pursuant to R20-6-404.

F. Applicability of the rule

1. A.R.S. § 20-401.07 and this rule apply to all insurance transacted by an unauthorized insurer with an industrial insured, whether procured through negotiation or by an application, in whole or in part, occurring or made within or outside this state.
2. A.R.S. § 20-401.07 and this rule apply to all insurance transacted by an unauthorized insurer with an industrial insured for which premiums, in whole or in part, are remitted directly or indirectly from within or outside this state.

G. Return and premium required – Every industrial insured under a contract procured from an unauthorized insurer shall pay to the Director, before April 1 next following the calendar year, a premium receipt tax of 3% of the gross premiums charged, deducted or allocated, to persons, residents or property located in, or contracts to be performed in this state and by A.R.S. § 20-401.07 deemed to be insurance effectuated or continued in this state. The return for premium receipts tax shall be prepared, executed and filed on Form E-166 attached hereto and made part hereof.

H. Risks partly in this state

1. If an industrial insured claims that the contract with an unauthorized insurer covers risks or exposures only partly in this state, the industrial insured shall file, in addition to and accompanying the premium receipts tax return, a certified statement clearly disclosing information necessary for a determination of the criteria of percentage allocation of A.R.S. § 20-401.07, including but not limited to:
   a. Percentage of physical assets in Arizona.
   b. Percentage of employee payroll in Arizona.
   c. Percentage of sales in Arizona.
   d. Percentage of taxable income reportable in Arizona.
2. In addition to the statements required by (H)(1) hereof, each industrial insured shall file with the Director the computations by which the tax payable has been computed on the portions of the premium which are properly allocable to the risk or exposure located in this state.

I. Exemptions – Persons contracting with unauthorized insurers claiming to be included in or exempt from the definition of "industrial insured" of A.R.S. § 20-401.07(B) shall file a certified statement clearly disclosing:

1. The risk or risks insured other than life, disability and annuity contracts and the identity of the insurer, the identity, title and functions of the full time employee acting as an insurance manager or buyer, or the identity, address and functions of a regularly and continuously retained qualified insurance consultant, and
2. The total aggregate annual premiums of the insured and the total number of full time employees of the insured.

J. Additional information – In addition to the certified statements required by this rule, the Director may and if requested the industrial insured or insured, shall furnish to the Director additional information, including, but not limited to:

1. The mode of premium payment showing the percentage paid by employer and employee;
2. The amount of annual premium applied to life, disability and annuity policies if additional risks are insured;
3. A statement of loss claim ratio for the preceding year by policy type, and
4. The amount of reserve for policies and contracts by type of policy.

K. Failure to pay claims – Applications for classification as, or exemption from, the definition of the industrial insureds may be denied or rejected if the applicant has failed to pay any claims or loss within the provisions of an insurance contract issued by such applicant or by an unauthorized insurer for the applicant, or deemed to be insurance effectuated or continued in this state. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action in law or equity in a court of this state.

L. Reciprocal state – The list of the states and territories qualified as reciprocal states, and maintained by the Director pursuant to the authority and instruction of A.R.S. § 20-401.04 is by reference made part of this rule.

M. Effective date

1. This rule shall become effective April 1, 1973. All reports and returns to be filed or filed on or after the effective date of this rule, except as herein provided, shall conform to the provisions of this rule as of the effective date, April 1, 1973. Because of the fact that compliance with the provisions of A.R.S. § 20-401.07 and this rule involve complex matters that are not fully resolvable by the effective date, the time for filing initial returns and statements is hereby extended until July 1, 1973, provided that the premium tax due accompanies the filing of such return or statement.
2. Any industrial insured wishing to comply with A.R.S. § 20-401.07 and this rule prior to such extended date may do so by filing with the Director the required return, statement and premium tax due.

N. Other approved dates – For good cause shown the Director may authorize industrial insured to make, complete and file returns, statements and reports required by statute or this rule on dates other than those required, if applied for in writing not less than 10 days prior to the due date of such return, statement, report or accounting.

O. Severability – If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

P. Forms – The filing of returns, reports, statements or accountings prescribed by this rule are not subject of a precise or specific form other than Forms A-1 and A-2 hereof. Filings shall adequately disclose the information required by statutes and this rule. If additional specific forms are hereafter adopted by the Department, such specific forms shall be prepared, executed and filed in accordance with such forms and the instructions attached thereto.

Q. Adoption – Notice of proposed adoption of this rule, together with a true copy thereof was filed in the Office of the Secretary of State on the 26th day of March, 1973, and a hearing thereof, pursuant to such notice, was held on the 24th day of April,

1973, when, pursuant to arguments made at such hearing and written memorandum filed thereafter, this rule was adopted on the 24th day of April, 1973. This rule shall become effective on the first day of April, 1973, pursuant to subsection (M) hereof.

Historical Note
Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1).

R20-6-208. Expired

Historical Note
Former General Rule Number 73-34. R20-6-208 recodified from R4-14-208 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-209. Unfair Sex Discrimination

A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, and 20-448.

B. Purpose. The purpose of this rule is to eliminate the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers and to implement A.R.S. § 20-448, Unfair Discrimination.

C. Definitions:
1. "Contracts" mean any insurance policy, plan or binder, including any rider or endorsement thereto offered by an insurer.
2. "Insurer" has the meaning of A.R.S. §§ 20-104 and 20-106(c).

D. Applicability and scope. This rule shall apply to all contracts delivered or issued for delivery in this state by an insurer on or after the effective date of this rule and to all existing group contracts which are amended on or after the effective date of this rule.

E. Availability requirements. Availability of any insurance contract shall not be denied to an insured or prospective insured on the basis of sex or marital status of the insured or prospective insured. The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced on the basis of sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under Title 20, Arizona Revised Statutes. Nothing in this rule shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependents benefits.

F. Illustrations. Illustrations of practices prohibited by this rule include, but are not limited to, the following:
1. Denying coverage to persons of one sex gainfully employed at home, employed part-time or employed by relatives when coverage is offered to persons of the opposite sex similarly employed.
2. Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.
3. Denying maternity benefits to insureds or prospective insureds purchasing an individual contract when comparable family coverage contracts offer maternity benefits.
4. Denying, under group contracts, dependent coverage to a spouse of an employee of one sex when dependent coverage is available to an employee of the opposite sex.
5. Denying disability income contracts to employed persons of one sex when coverage is offered to persons of the opposite sex similarly employed.
6. Treating complications of pregnancy differently from any other illness or sickness under the contracts.
7. Restricting, reducing, modifying or excluding benefits relating to coverage involving the genital organs of only one sex.
8. Offering lower maximum monthly benefits to persons of one sex than to persons of the opposite sex who are in the same classification under a disability income contract.
9. Offering more restrictive benefit periods and more restrictive definitions of disability to persons of one sex than to persons of the opposite sex in the same classifications under a disability income contract.
10. Establishing different conditions by sex under which the policyholder may exercise benefit options contained in the contract.
11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless such limitation is for the purpose of defining persons eligible for dependent's benefits.
12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contracts, the amount of benefits payable, or any term, condition or type of coverage on account of sex or marital status in all lines of insurance.

G. Severability. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

H. Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the office of the Secretary of State of the State of Arizona but not before April 1, 1977.

Historical Note
Adopted effective June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1).

R20-6-210. Group Coverage Discontinuance and Replacement

A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, and 20-1110.

B. Scope. This rule is applicable to all insurance policies and subscriber contracts issued or provided by an insurance company or a non-profit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions (or associations).

C. Definition. The term "group-type basis" means a benefit plan, other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:
1. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.
2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.
3. There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit service corporation.
4. There is sponsorship of the plan by the employer, union (or association).

D. Effective date of discontinuance for non-payment of premium or subscription charges
1. If a policy or contract subject to these rules and regulations provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.
2. If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of third scheduled work day after the date upon which the notice is delivered.

E. Requirements for notice of discontinuance
1. Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in any instance in which the plan involves employee contributions, that if the policyholder or in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.
2. The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the employees or members concerned indicating such discontinuance and the effective date thereof, and urging the employees or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon such discontinuance.

F. Extension of benefits
1. Every group policy or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract, as required by the following paragraphs of this subsection.
2. In the case of a group life plan which contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy shall not operate to terminate such extension.
3. In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.
4. In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered "reasonable" if it provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (e.g., an accident).
5. Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

G. Continuance of coverage in situations involving replacement of one carrier by another
1. This Section shall indicate the carrier responsible for liability in those instances in which one carrier's contract replaces a plan of similar benefits of another.
2. Liability of prior carrier. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.
3. Liability of succeeding carrier.
   a. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and activity at work and non-confinement rules) shall be covered by that carrier's plan of benefits.
   b. Each person not covered under the succeeding carrier's plan of benefits in accordance with subparagraph (a) above must nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.
      i. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.
      ii. Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:
         (1) The date the individual becomes eligible under the succeeding carrier's plan as described in subparagraph (a) above.
         (2) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be eligi-

ble dependent, as the case may be).

(3) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsection (F) requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by subsection (F), or, if the prior carrier's policy or contract is not subject to that subsection, would have been required of that carrier had its policy or contract been subject to subsection (F) at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

c. In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection (G) during the period of time this limitation applies under the new plan shall be the lessor of:

i. The benefits of the new plan determined without application of the preexisting conditions limitation; and

ii. The benefits of the prior plan.

d. The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to similar deductible provision.

e. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this Section, benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

H. Effective date. This rule shall become effective 120 days after a certified copy of this rule is filed in the office of the Secretary of State of the State of Arizona.

Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1).

R20-6-211. Life Insurance Solicitation

A. Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.

B. Purpose

1. The purpose of this rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of the similar plans of life insurance.
2. This rule does not prohibit the use of additional material which is not in violation of this rule or any other state statute or rule.

C. Scope

1. Except as hereinafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any issuer of life insurance contracts including fraternal benefit societies.
2. Unless otherwise specifically included, the rule shall not apply to:
   a. Annuities.
   b. Credit life insurance.
   c. Group life insurance.
   d. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA).
   e. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

D. Definitions. For the purpose of this rule, the following definitions shall apply:

1. "Buyer's Guide." A Buyer's Guide is a document which contains, and is limited to, the language contained in the Appendix to this rule or language approved by the Director of Insurance.
2. "Cash dividend." A cash dividend is the current illustrated dividend which can be applied toward payment of the gross premium.
3. "Equivalent Level Annual Dividend." The Equivalent Level Annual Dividend is calculated by applying the following steps:
   a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the tenth and twentieth policy years.
   b. Divide each accumulation of Step (a) by an interest factor that converts it onto one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in Step (a) over the respective periods stipulated in Step (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
   c. Divide the results of Step (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
4. "Equivalent Level Death Benefit." The Equivalent Level Death Benefit of a policy or term life insurance rider is an amount calculated as follows:
   a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the tenth and twentieth policy years respectively.
   b. Divide each accumulation of Step (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in Step (a) over the

respective periods stipulated in Step (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

5. "Generic Name." Generic Name means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.
6. "Life Insurance Cost Indexes."
   a. Life Insurance Surrender Cost Index. The Life Insurance Surrender Cost Index is calculated by applying the following steps:
      i. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.
      ii. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in Step (i).
      iii. Divide the result of Step ii. (Step (i) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in Step (ii). (Step (i) for guaranteed cost policies) over the respective periods stipulated in Step (i). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
      iv. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in Step (i) and dividing the result by the respective factors stated in Step (iii) (this amount is the annual premium payable for a level premium plan).
      v. Subtract the result of Step (iii) from Step (iv).
      vi. Divide the result of Step (v) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
   b. "Life Insurance Net Payment Cost Index." The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.
7. "Policy Summary." For the purposes of this rule, Policy Summary means a written statement describing elements of the policy including but not limited to:
   a. A prominently placed title as follows: *Statement of Policy Cost and Benefit Information.*
   b. The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary.
   c. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.
   d. The generic name of the basic policy and each rider.
   e. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity whichever is earlier.
      i. The annual premium for the basic policy.
      ii. The annual premium for each optional rider.
      iii. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.
      iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.
      v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)
      vi. Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.
   f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary includes the maximum annual percentage rate.
   g. Life Insurance Cost Indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.
   h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.
   i. A Policy Summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed in addition to a statement in close proximity to the Equivalent Level Annual Dividend as follows: An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide.
   j. A statement in close proximity to the Life Insurance Cost Indexes as follows: An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide.
   k. The date on which the Policy Summary is prepared. The Policy Summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in (7)(e) of this subsection shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for

each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

E. Disclosure requirements

1. The insurer shall provide, to all prospective purchasers, a Buyer's Guide and a Policy Summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains such an unconditional refund offer, in which event the Buyer's Guide and Policy Summary must be delivered with the policy or prior to delivery of the policy.
2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
3. In the case of policies whose Equivalent Level Death Benefits do not exceed $5,000, the requirement for providing a Policy Summary will be satisfied by delivery of a written statement containing the information described in subsection (D), paragraph (7), subparagraphs (b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).

F. General rules

1. Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this rule. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.
2. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.
3. Terms such as financial planner, investment advisor, financial consultant, or financial counselling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sales unless such is actually the case.
4. Any reference to policy dividends must include a statement that dividends are not guaranteed.
5. A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
6. A presentation of benefits shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately in close proximity thereto.
7. A statement regarding the use of the Life Insurance Cost Indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
8. A Life Insurance Cost Index which reflects dividends or an Equivalent Level Annual Dividend shall be accompanied by a statement that it is based on the company's current dividend scale and not guaranteed.
9. For the purposes of this rule, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

G. Failure to comply. Failure of an insurer to provide or deliver a Buyer's Guide, or a Policy Summary as provided in subsection (E) shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

H. Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona but not before January 1, 1979.

APPENDIX

Life Insurance Buyer's Guide

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

– Decide how much life insurance you should buy,

– Decide what kind of life insurance policy you need, and

– Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1)

what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
   Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index

of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.
(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important Things To Remember – A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

Historical Note

Adopted effective August 1, 1977 (Supp. 77-4). Amended effective March 27, 1976 (Supp. 78-2). Correction, Historical Note for Supp. 77-4 should read adopted effective January 1, 1979 filed August 1, 1977. Historical Note for Supp. 78-2 should read Appendix amended effective January 1, 1979 filed March 27, 1978 (Supp. 79-5). Editorial correction, (D)(7)(a), title now shown in italics (Supp. 81-1). R20-6-211 recodified from R4-14-211 (Supp. 95-1).

R20-6-212. Readable and Understandable Policy

A. Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.

B. Purpose. The purpose of this rule is to provide an orderly procedure for complying with the provisions of A.R.S. § 20-1110.01.

C. Definitions. As used in this rule, unless the context otherwise requires:
1. A "readable insurance policy" is a contract designed to be read and reasonably understood by a person without special knowledge or training.
2. "Policy" means contract or agreement for or effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof.

D. Scope
1. This rule applies to individual and personal line automobile policies and individual and personal line dwelling policies (4 family units or less) delivered or issued for delivery in Arizona or amended on or after January 1, 1979. This rule shall not apply to any such dwelling policy covering a mobile home until after December 31, 1979.
2. This rule applies to individual and personal line automobile policies and individual and personal line dwelling policies (4 family units or less) that are renewed on or after January 1, 1982.
3. The Director reserves the right to extend the scope of this rule to other kinds of insurance in the future.

E. Compliance
1. Each insurer is required to test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).
2. A total readability score of 40 or more on the Flesch scale is required.
3. All policies, outlines of coverage or brochures within the scope of this rule shall be filed with the Director accompanied by a sworn affidavit setting forth the Flesch score and a sworn statement of compliance with the guidelines set forth in this rule.

F. Readable policy guidelines
1. The policy as a legal document. Revision of the insurance policy to make it more readable must not lead to its devaluation as a legal document. The policy must comply with all statutory and regulatory requirements.
2. Arizona standard fire policy. A.R.S. § 20-1110.01 modifies the provisions of Article 7, Chapter 6, Title 20, Arizona Revised Statutes, relating to the Arizona standard fire policy. All policies within the scope of the rule, including any policy that contains, in whole or in part, the

provisions of the Arizona standard fire policy, shall comply with all requirements of this rule.

3. General organization of text.
   a. A readable policy shall be divided into logically arranged sections for ease of locating desired content.
   b. Each section shall be self-contained as to provisions relating solely to that section.
   c. General policy provisions applying to all or several coverages alike shall be located in a common area.
   d. Non-essential provisions shall be eliminated.
   e. Defined words and terms shall be selected with care and placed in a separate definition section to appear early in the policy format.
4. Visual aids to readability.
   a. Type size shall not be smaller than 8 point and type style shall be selected with legibility as the primary consideration.
   b. Captions and headings shall be clearly distinguishable from the general text.
   c. White space separating coverages, policy sections and columns shall be sufficient to make a distinct separation.
   d. Defined words and terms shall be clearly distinguishable from the general text.
5. Language usage suggestions.
   a. The policy should be written in everyday, conversational language.
   b. Use short, simple sentences and words in common usage wherever possible.
   c. Use a personal style, personal pronouns, and present tense, active verbs, wherever possible.

G. Outline of coverage. The requirements for a readable insurance policy contained in this rule may be complied with by an insurer providing to the policyholder an outline of coverage or brochure which accompanies the policy. Such an outline of coverage or brochure must comply with the readability requirements contained in this rule for a policy. If an insurer elects to use such an outline of coverage or brochure, the policy that is provided to the policyholder and accompanied with the outline of coverage or brochure need not comply with the readability requirements of this rule. If an insurer elects to use such an outline of coverage or brochure, the outline of coverage or brochure must contain all provisions of the policy.

H. This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona.

Historical Note

Adopted effective March 27, 1978 (Supp. 78-2). Editorial correction see subsection (A) citation to A.R.S. (Supp. 78-4). Editorial correction see subsections (B) and (F) citation to A.R.S. (Supp. 78-6). R20-6-212 recodified from R4-14-212 (Supp. 95-1).

R20-6-213. Unfair Discrimination on the Basis of Blindness, Partial Blindness

A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.

B. Purpose. The purpose of this rule is to ensure that individuals who are blind, partially blind, or have a physical disability will not be unfairly discriminated against in the rates charged for or the availability of any contract of life insurance or life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract; and will not be unfairly discriminated against in the amount of premium, policy fees or rates charged for or the availability of any policy or contract of insurance other than life or in the benefits payable thereunder or in any of the terms or conditions of such contract, or in any manner whatever.

C. Definitions:
1. "Contract" means any policy of or agreement for or effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof.
2. "Person" shall mean "person" as defined in A.R.S. § 20-105.

D. Scope. This rule shall apply to all contracts delivered or issued for delivery in this state by a person on or after the effective date of this rule. This rule shall also apply to any group or blanket contract which has been delivered or issued for delivery in this state before the effective date of this rule, but not until such contract is amended or renewed at or after the later of the following times:
1. The effective date of this rule, or
2. If the contract provides benefits in connection with or pursuant to the provisions of a collective bargaining agreement which is in force on the effective date of this rule, when such collective bargaining agreement expires.

E. Prohibition. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class: Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

F. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his/her eyesight. However, an insurer may exclude from coverage disabilities, consisting solely of blindness or partial blindness, when such condition existed at the time the policy was issued.

G. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

Historical Note

Adopted effective November 21, 1977 (Supp. 77-6). Amended effective March 27, 1978 (Supp. 78-2). Amended subsection (E), deleted subsection (F) and added new subsections (F) and (G) effective December 3, 1986 (Supp. 86-6). R20-6-213 recodified from R4-14-213 (Supp. 95-1).

R20-6-214. Expired

Historical Note

Adopted effective October 26, 1979 (Supp. 79-5). R20-6-214 recodified from R4-14-214 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-215. Forms for Replacement of Life Insurance Policies and Annuities

The Department adopts, incorporates, and approves as its own the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference, on file with the Office of Secretary of State, and copies available from the Department of Insurance, 2910 North 44th Street, Phoenix, Arizona 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

1. For the purpose of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation, Appendix A – Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.
2. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation, Appendix B – Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation, Appendix C – Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

Historical Note

Adopted effective September 7, 1981 (Supp. 81-3).
Amended subsections (D) thru (H), deleted Agent's Statement and Exhibit D effective March 30, 1983 (Supp. 83-2).
R20-6-215 recodified from R4-14-215 (Supp. 95-1).
Amended by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4).

R20-6-215.01. Forms for Buyer's Guide for Annuities

The Department adopts, incorporates, and approves as its own the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference, on file with the Office of Secretary of State, and copies available from the Department of Insurance, 2910 North 44th Street, Phoenix, Arizona 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer's Guide: Annuity Disclosure Model Regulation, Appendix – Buyer's Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I – Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4).

R20-6-216. Life and Disability Insurance Policy Language Simplification

A. Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.

B. Purpose. The purpose of this rule is to establish minimum standards for language used in policies, contracts and certificates of life insurance, disability insurance, credit life insurance and credit disability insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.

C. Definitions. As used in this rule, unless the context otherwise requires:
1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state.

D. Applicability
1. This rule shall apply to all life and disability insurance policies delivered or issued for delivery in this state by any company on or after the date such forms must be approved under this rule, but nothing in this rule shall apply to:
   a. Any policy which is a security subject to federal jurisdiction;
   b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy; however, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state;
   c. Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
   d. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this rule; or
   e. The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under this rule.
2. Except as provided in R20-6-212, no other rule of this state setting language simplification standards shall apply to any policy forms.

E. Minimum policy language simplification standards
1. In addition to any other requirements of law, no policy forms, except as stated in subsection (D), shall be delivered or issued for delivery in this state on or after the dates such forms must be approved under this rule unless:
   a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in paragraph (3) of this subsection;
   b. It is printed, except for specification pages, schedules and tables, in not less than 10 point type, one point leaded;
   c. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and
   d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.
2. For the purposes of this subsection, a Flesch reading ease test score shall be measured by the following method:
   a. For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two 200 word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.
   b. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.
   c. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

d. The sum of the figures computed under (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
e. For purposes of subparagraphs (b), (c), and (d), the following procedures shall be used:
i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word,
ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence, and
iii. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
f. The term "text" as used in this subsection shall include all printed matter except the following:
i. The name and address of the insurer; the name, number or title of the policy, the table of contents or index, captions and subcaptions; specification pages, schedules or tables; and
ii. Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology, any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the insurer identifies the language or terminology excepted by this subdivision (ii) and certifies, in writing, that the language or terminology is entitled to be excepted by this subdivision.

3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with subsection (G) of this rule. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

F. Construction. Nothing in this rule shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.

G. Powers of the Director. The Director may authorize a lower score than the Flesch reading ease score required in subparagraph (E)(1)(a) whenever, in his sole discretion, he finds that a lower score:
1. Will provide a more accurate reflection of readability of a policy form;
2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
3. Is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation or agency interpretation.

H. Effective dates. Except as provided in subsection (D), this rule applies to all policy forms filed on or after January 1, 1982. No new policy form shall be delivered or issued for delivery in this state on or after January 1, 1982, unless it has been filed pursuant to A.R.S. § 20-1110 and is in compliance with this rule. All other policy forms which have been approved or permitted to be issued prior to January 1, 1982, shall meet the standards set by this rule by January 1, 1984.

Historical Note

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1).

R20-6-217. Coordination of Benefits

A. Applicability
1. This rule applies to all group disability insurance policies, group subscriber contracts of hospital and medical service corporations and of health care services organizations, and group disability policies of benefit insurers, as well as such group type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group which contain a coordination of benefits provision. Group type contracts answering this description are included whether denominated as "franchise" or "blanket" or some other designation.
2. This rule does not apply to:
a. Individual or family policies or individual or family subscriber contracts except as provided for in paragraph (1) above.
b. Group or group type hospital indemnity benefits (written on a non-expense incurred basis) of $30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at time of claim.
c. School accident type coverages, written on either a blanket, group or franchise basis.

B. Definitions
1. "Allowable expense" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.
b. A plan which takes "Medicare" or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan" within the coordination of benefits provisions of a group policy or subscriber contract means the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim.
4. "School accident type coverages" means coverage covering grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to and from school," for which the parent pays the entire premium.

C. Order of benefit determination

1. When a claim under a plan with a coordination of benefit provision involves another plan which also has a coordination of benefit provision, the order of benefit determination shall be made as follows:
   a. The benefits of a plan that covers the person claiming benefits other than as a dependent shall be determined before those of the plan which covers the person as a dependent.
   b. The benefits of a plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year.
      The word "birthday" as used in this paragraph refers only to month and day in a calendar year, not the year in which the person was born.
   c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order;
      i. first, the plan of the parent with custody of the child;
      ii. then, the plan of the spouse of the parent with custody of the child; and
      iii. finally, the plan of the parent not having custody of the child.
   d. Notwithstanding paragraph (c) above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan which covers a person as an employee (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan which covered a claimant longer are determined before those of the plan which covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions.
1. A plan with an order of benefit determination provision which complies with this rule, herein called a complying plan, may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses an order of benefit determination provision which is inconsistent with that contained in this rule, herein called a noncomplying plan, on the following basis:
   a. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
   b. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, as the secondary plan. In such a situation, such payment shall be the limit of the complying plan's liability, except as provided in subparagraph (d).
   c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whether information becomes available as the actual benefits of the noncomplying plan.
   d. If the noncomplying plan pays benefits so that the claimant receives less in benefits than he or she would have received had the noncomplying plan paid or provided its benefits as the primary plan then the complying plan shall advance to or on behalf of the claimant an amount equal to such difference which advance shall not include a right to reimbursement from the claimant.

E. Severability. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.

Historical Note

Adopted effective September 14, 1982 (Supp. 82-3). Amended subsections (C) and (D), deleted (F) effective January 1, 1987, filed December 16, 1986 (Supp. 86-6). R20-6-217 recodified from R4-14-217 (Supp. 95-1).

Editor's Note: The following Section expired under A.R.S. § 41-1056(E) on September 30, 2001 at 8 A.A.R. 491. The Notice of Rule Expiration was not received until January 9, 2002. Therefore, the repeal of the rule noted in the Historical Note is moot (Supp. 02-1).

R20-6-218. Repealed

Historical Note

Adopted effective November 9, 1984 (Supp. 84-6). R20-6-218 recodified from R4-14-218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5443, effective November 16, 2001 (Supp. 01-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1) (see Editor's Note above).

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

R20-6-301. Expired

Historical Note

Former General Rule Number 3. R20-6-301 recodified from R4-14-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-302. Expired

Historical Note

Former General Rule 62-11. R20-6-302 recodified from R4-14-302 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-303. Withdrawal of Insurers from the Insurance Business and Release of Statutory Deposit

A. WHEREAS, A.R.S. § 20-143 confers upon the Director of Insurance the power and discretion to make reasonable rules and regulations necessary for effectuating any provisions of Title 20, such rules and regulations being subject to the provisions of A.R.S. §§ 41-1001 through 41-1008, and

B. WHEREAS, it appears that the regulations hereafter proposed in this General Rule are required to assure preservation of the public peace, health and safety, and

C. WHEREAS, the regulations embodied in this rule shall be construed as severable, so that should one or more Sections of the rule be held invalid, the remaining Sections shall not be adversely affected, and

D. WHEREAS, A.R.S. § 20-588(B), relating to the release of deposits under Title 20, requires application to, and the written order of, the Director, and

E. WHEREAS, in order to establish an orderly procedure whereby insurers desiring to withdraw from the insurance business, and thereafter to secure the release of their deposits made under A.R.S. § 20-581, may do so without placing their policyholders or former policyholders and creditors in jeopardy, the Director of Insurance (hereafter called "the Director") adopts the following rule:

1. Reinsurance – An insurer in seeking to withdraw from the insurance business (hereafter called "the insurer") shall first reinsure all of its business in force with another insurer by entering into an agreement of bulk reinsurance which shall become effective only when filed with and approved in writing by the Director pursuant to A.R.S. §§ 20-732 or 20-734, as may be applicable. The agreement of bulk reinsurance shall provide for the assumption by the reinsurer of all the insurer's liability as to policyholder claims incurred but unreported as of the effective date of the agreement and it may also include recapture provisions exercisable by the insurer in the event its withdrawal from the insurance business as contemplated by this rule is not completed.
2. Withdrawal from the insurance business
   a. With the approval of the Director, an insurer may withdraw from the insurance business either:
      i. By amending its articles of incorporation pursuant to A.R.S. § 20-707, so as to eliminate its insuring powers and to adopt a new corporate name which shall not include the word "insurance," or
      ii. By dissolution pursuant to A.R.S. §§ 10-361 to 10-363 inclusive. The insurer shall not seek from the Arizona Corporation Commission the issuance of a certificate of dissolution or of withdrawal until authorized by the Director, as hereinafter provided. The insurer shall not file with the Arizona Corporation Commission a certificate of amendment of its articles of incorporation without first obtaining the written approval of the Director to such amendment and filing. The Director may authorize or approve any such filing if it is a part of a program for withdrawal from the insurance business and release of statutory deposit calculated to protect policyholders and creditors in accordance with the further provisions of this rule.
   b. Prior to the filing with the Arizona Corporation Commission of either a certificate of amendment to its articles of incorporation or a resolution of dissolution, the insurer shall file with the Director a certified copy of a resolution passed at a meeting of stockholders or members, as may be applicable, adopting the amendment to the articles of incorporation or the resolution of dissolution.
   c. At the time of filing the certified copy of resolution specified in subparagraph (b) of this paragraph, the insurer shall surrender to the Director its certificate of authority issued pursuant to A.R.S. § 20-216. If no such surrender is made within 10 days of completion of the filing specified in subparagraph (b) of this paragraph, the Director may revoke or suspend the certificate of authority as provided by A.R.S. § 20-219, or take any other appropriate action to compel surrender of said certificate.
3. Release of statutory deposit
   a. The Director may approve the amendment of the articles of incorporation of the insurer to eliminate its insuring powers and its change of name or the resolution of dissolution, and may, pursuant to A.R.S. § 20-588, approve the release to the insurer of deposited funds in accordance with the following procedure:
      i. The insurer shall file with the Director an application for release of deposited funds together with a statement of its financial condition verified by its president and secretary. The statement shall include a schedule of all assets and liabilities, with itemization and adequate detail with respect to all outstanding liabilities, if any. The statement shall reflect the condition of the insurer as of a date not more than 60 days prior to the day the insurer files with the Director its application for release of its statutory deposit.
      ii. If there are any outstanding liabilities, actual or contingent, set forth in the schedule required to be filed under subdivision (i) of this subparagraph, there shall also be filed with the Director a plan of extinguishment of substantially all liability for the security of which the deposit is held, together with such documents or assurances as may be reasonably necessary to insure such extinguishment. For the purpose of this rule, the term "substantially all liability" is defined as all known or reasonably ascertainable direct obligations, whether or not liquidated in amount and shall include any former policyholder who may have a claim, or a right to a refund under a policy of insurance. The Director may require an agreement from a person whose financial responsibility is demonstrated to the Director guaranteeing all obligations of the insurer of any kind, other than policyholder claims covered by the agreement of bulk reinsurance.
      iii. The Director shall thereupon appoint a time and place for hearing the application for release of deposit, which shall be not less than 10 days after notice is given to creditors as provided in subdivision (iv) of this subparagraph, and notice thereof shall be given in accordance with A.R.S. § 20-163.
      iv. The insurer shall thereupon give notice to all known creditors of the date, place, nature and purpose of the hearing. The notice shall be published in a newspaper of general circulation published in the county in which the insurer has its principal place of business and as may be approved by the Director, and by mailing a copy of said notice by first class mail, postage prepaid, to the last known address of all known or reasonably ascertainable creditors, and such other persons designated by the Director. The notice shall inform such creditors that a verified statement of financial condition, together with a copy of the plan for extinguishment of remaining liabilities, if applicable, has been

filed with the Director and is available for their inspection and shall advise such creditors to present to the Director prior to the hearing any objections or additional claims. A copy of such notice, in a form approved by the Director, together with an affidavit of publication and mailing, shall be filed with the Director prior to the hearing.

v. Unless there is an assumption by reinsurance substantially all the insurer's policy liability, including liability on claims incurred but unreported as of the effective date of the agreement of bulk reinsurance referred to in paragraph (1), subsection (E) hereof, the notice required by subdivision (iv) of this subparagraph shall also be given to all former policyholders who may or could have outstanding claims not barred by statute or by policy limitations.

vi. Prior to the hearing, the Director may cause to be conducted an examination of the affairs, transactions, accounts, records and assets of the insurer pursuant to Chapter 1, Article 2, Title 20, A.R.S. The cost of any such examination shall be taxed to the insurer.

vii. At the hearing, the Director shall review evidence presented by the insurer as to its compliance with A.R.S. § 20-588, and any other evidence available to the Director, together with any objections or additional claims presented by creditors whose claims have not been reinsured or otherwise secured. On his own motion, or on request of the insurer, or of any such creditors, policyholders, or former policyholders, but only for good cause shown, the Director may adjourn the hearing from time to time.

viii. A plan for extinguishment of substantially all liability for the security of which the deposit is held may provide for the use of the deposit for the payment of claims of creditors, policyholders and former policyholders whose claims have not been reinsured or otherwise secured. If the proposed plan contains such a provision, the Director shall exercise his discretion in approving the plan so as to provide the maximum reasonable security to creditors, policyholders and former policyholders whose claims are unsatisfied by such payment, or he may condition his approval upon an amendment of the plan by providing for partial withdrawals of deposits as claims are extinguished and by providing for the establishment of an escrow to insure extinguishment of substantially all liability for the security of which the deposit is held, or such other method of protecting such creditors and former policyholders as shall appear to be reasonable.

ix. At such time as the Director has determined that all creditors, former policyholders and policyholders of the insurer are adequately secured and the insurer has demonstrated that it has complied with A.R.S. § 20-588 and this rule, the Director shall issue a written order directing release of the deposit and authorizing the filing with the Arizona Corporation Commission of the amendment of the articles of incorporation eliminating insuring powers and changing name or the filing of the resolution of dissolution of the insurer; said release to be conditioned upon filing with the Director proof of filing with the Arizona Corporation Commission the amendment of the articles of incorporation or the resolution of dissolution as approved by the Director.

x. Should the Director find that the insurer is unable to extinguish substantially all of its liability for the security of which the deposit is held, or otherwise has not complied with this rule, he shall decline the application by written notice to the insurer setting forth his reasons therefor. The insurer thereafter may reapply for release of its deposit when it extinguishes, or is able to submit an acceptable plan for the extinguishment of, substantially all of its liability for the security of which the deposit is held, which application shall be acted upon as in the case of an original application.

xi. The Director may, in his discretion, decline to approve any application for release of a deposit, or any part thereof, until such time as the statute of limitations has run as to any disclosed or undisclosed liability of the insurer.

4. Qualification of reinsurance carrier. The contract of reinsurance, as above provided, may be entered into only with a reinsurer approved by the Director. If the withdrawing insurer has policies of insurance in force within the State of Arizona, or has creditors within the State of Arizona, the Director may, as a prerequisite to the approval of any plan for the extinguishment of liability of the withdrawing company, require that the reinsurer be licensed to do business within the State of Arizona.

5. Applicability of rule to foreign and alien insurers. The provisions of this rule shall apply with equal force and effect, to the extent permissible, to any deposits required by the Director and made by any foreign or alien insurer, including any deposit made pursuant to the retaliatory provisions of A.R.S. § 20-230.

6. Exemptions – The provisions of this rule shall not be applicable to:
   a. Exchange and substitution of cash or eligible securities by an insurer as authorized by A.R.S. § 20-586.
   b. Withdrawal of excess deposits by an insurer, either cash or eligible securities, as authorized by A.R.S. §§ 20-587 and 20-588(A)(2).
   c. Release of the deposit of any insurer as directed by the order of a court of competent jurisdiction, as provided by A.R.S. § 20-588(A)(3).

Historical Note

Former General Rule 72-29. R20-6-303 recodified from R4-14-303 (Supp. 95-1).

R20-6-304. Reserved

R20-6-305. Expired

Historical Note

Adopted effective September 13, 1978, except that it shall apply to the accounting treatment for unearned premium reserves and reinsurance premium receivables for credit life disability insurance on January 1, 1979, and all annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R.

491, effective September 30, 2001 (Supp. 02-1).

R20-6-306. Reserved

R20-6-307. Life and Disability Reinsurance Agreements

A. Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited resinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

B. Definitions

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance.
4. "Director" means the Director of the Arizona Department of Insurance.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

C. Accounting Requirements

1. Unless authorized by the director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
   a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
   b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
   c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.
   d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
   e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
   f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
   g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
   h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
   i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
   j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

D. Written Agreements

1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the "as of" date of the statutory financial statement.

2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
   a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
   b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). R20-6-307 recodified from R4-14-307 (Supp. 95-1). Amended effective December 7, 1995 (Supp. 95-4).

Table A. Risk Categories

Risk Categories:

(a). Morbidity (d). Credit Quality
(b). Mortality (e). Reinvestment
(c). Lapse (f). Disintermediation

	a	b	c	d	e	f
Disability Insurance, other than long-term care or long-term disability insurance	+	0	+	0	0	0
Long-term care or long-term disability insurance	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-par Permanent Life	0	+	+	+	+	+
Traditional Non-par Term Life	0	+	+	0	0	0
Traditional Par Permanent Life	0	+	+	+	+	+
Traditional Par Term Life	0	+	+	0	0	0
Adjustable Premium Permanent Life	0	+	+	+	+	+
Indeterminate Premium Permanent Life	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium, with dump-in premiums allowed	0	+	+	+	+	+

+ - Significant 0 - Insignificant

Historical Note
Adopted effective December 7, 1995 (Supp. 95-4). Corrected misspelled word “adjustable” as submitted in final rule (Supp. 98-3).

R20-6-308. Determination of Insurer’s Hazardous Financial Condition

A. The Director shall consider the following criteria, either singly or in combination, to determine whether any insurer is in such condition as to render the continuance of its business hazardous to its policyholders or the people of this state:
1. Whether any financial or market conduct examination reports, audited financial reports or the insurer’s financial statement filings contain any adverse findings or information with respect to its financial condition;
2. Whether any reports or information received from the National Association of Insurance Commissioners’ Insurance Regulatory Information System are adverse to the insurer with respect to its financial condition;
3. Whether the ratios of commission expense, general insurance expense, policy benefits and reserve increases to annual premium and net investment income are adequate in relation to the insurer’s capital and surplus;
4. Whether premium income is adequate in relation to capital and surplus;
5. Whether the insurer’s assets are of sufficient fair market value, liquidity, and diversity to assure its ability to meet its outstanding obligations as they mature;
6. Whether the insurer’s reinsurance provides adequate protection for the insurer’s remaining surplus after taking into account the insurer’s cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;
7. Whether the insurer’s operating loss in the last 12-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than 50% of such insurer’s remaining surplus as regards policyholders that is in excess of the minimum required;
8. Whether asset values are attributable to investments in or transactions with parents, subsidiaries, or affiliates;
9. Whether any affiliate, subsidiary or reinsurer of the insurer is impaired, unable to meet its obligations as they come due, or in a condition that would render the continuance of its business hazardous to the insurer’s policyholders or the people of this state;

10. Whether contingent liabilities, pledges or guaranties of the insurer, either individually or collectively, total an amount which equals or exceeds the insurer's net worth so as to jeopardize its solvency;
11. Whether there is a substantial risk that the insurer will be called upon to meet its obligations under any contingent liability, pledge or guaranty;
12. Whether any "controlling person" of an insurer as defined in A.R.S. § 20-481(3) is delinquent in transmitting net premiums to such insurer;
13. Whether receivables are of doubtful collectibility;
14. Whether all persons possessing, directly or indirectly, the power to cause the direction of the management and policies of the insurer, whether as the result of an official position or corporate office held by the person or through "control" as defined in A.R.S. § 20-481(3), are adequately competent, experienced and of good character to exercise such power;
15. Whether an insurer has failed to fully respond to inquiries relative to the financial condition of the insurer or has furnished false or misleading information concerning such an inquiry;
16. Whether an insurer has filed any false or misleading sworn financial statement, or has made a false or misleading entry in its financial records, or has omitted any entry from its financial records necessary to make such records truthful and accurate, or has made any misrepresentation to lending institutions or to the general public regarding its affiliations;
17. Whether the insurer lacks adequate financial and administrative capacity to meet its obligations in a timely manner considering its growth;
18. Whether the company has experienced cash flow or liquidity problems.

B. For the purpose of determining an insurer's financial condition under this rule, the Director may disregard or adjust the value of assets or increase liabilities based upon consideration of the criteria set forth in subsection (A).

C. If the Director determines that any insurer is in such condition as to render the continuance of its business hazardous to its policyholders or the people of this state, then, in addition to any other action authorized by A.R.S. Title 20, the Director may issue an order requiring the insurer to:
1. Reduce the total amount of present and potential retained liability for policy benefits by obtaining reinsurance;
2. Reduce, suspend or limit the volume of insurance risk being accepted or renewed;
3. Reduce its general insurance and commission expenses by specified methods;
4. Increase its capital and surplus;
5. Suspend or limit principal or interest payments on surplus notes or the declaration and payment of dividends to its stockholders or to its policyholders;
6. File reports concerning the fair market value of its assets in accordance with A.R.S. § 20-235(C);
7. Limit or withdraw from certain investments or discontinue certain investment practices;
8. Establish the adequacy of premium rates in relation to the risks insured;
9. File, in addition to regular annual statements, interim financial reports in accordance with A.R.S. § 20-235(C).

D. A hearing demanded by an insurer aggrieved by an order of the Director under subsection (C) shall be closed to the public, but the hearing shall be open to the public if so requested in accordance with A.R.S. § 20-164(A).

E. This rule shall not be interpreted to limit or supersede any provision of A.R.S. Title 20 or any other provision of law pertaining to the powers of the Director or the regulation of the financial condition of insurers transacting insurance in this state.

Historical Note
Adopted effective March 22, 1993 (Supp. 93-1). R20-6-308 recodified from R4-14-308 (Supp. 95-1).

R20-6-309. Definitions

The definitions in this Section apply in R20-6-309 through R20-6-309.04.
1. "Basic reserves" mean reserves calculated in accordance with A.R.S. § 20-510(H).
2. "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined in this subsection and calculated using the 1980 CSO valuation tables, as defined in subsection (6), and, if elected, the optional minimum mortality standard for deficiency reserves in R20-6-309.02 (B).

   An insurer shall set the length of a particular contract segment equal to the minimum of the value *t* for which G_t is greater than R_t, as defined below. If G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy.

$$Gt = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

   when:
   x = original issue age;
   k = the number of years from the date of issue to the beginning of the segment;
   t = 1, 2, ...; *t* is reset to 1 at the beginning of each segment;
   $GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t*
   of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$Rt = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$

   However, an insurer may elect to increase or decrease R_t by 1% in any policy year, but R_t shall not be less than 1, when:
   x, k, and t are as defined above, and the insurer elects the mortality in R20-6-309.02(B)(3) for deficiency reserves
   $q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of R20-6-309.02 (B)(2) if R20-6-309.02(B)(3) is elected for deficiency reserves.
   However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t is deemed to be

1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t is deemed to be 0.

3. "Deficiency reserves" means the excess, if greater than 0, of:
   a. Minimum reserves calculated in accordance with A.R.S. § 20-510(L), over
   b. Basic reserves.
4. "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at date of issue.
5. "Maximum valuation interest rates" mean the interest rates defined in A.R.S. § 20-510(G) that an insurer shall use to determine the minimum standard for the valuation of life insurance policies.
6. "NAIC" means the National Association of Insurance Commissioners.
7. "1980 CSO valuation tables" means the NAIC 1980 Standard Ordinary Mortality Table (1980 CSO Table) without 10-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.
8. "Scheduled gross premium" means:
   a. For other than universal life insurance policies, the smallest illustrated gross premium at date of issue; and
   b. For universal life insurance policies, the smallest specified premium in R20-6-309.04(A)(3), if any, or the minimum premium in R20-6-309.04(A)(4).
9. "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, when the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:
   a. The present value of the death benefits within the segment, plus
   b. The present value of any unusual guaranteed cash value, as defined in R20-6-309.03(D), occurring at the end of the segment, less
   c. Any unusual guaranteed cash value occurring at the start of the segment, plus
   d. For the first segment only, the excess of item (i) over item (ii), as follows:
      i. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, dividend by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on a 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.
      ii. A net one-year term premium for the benefits provided for in the first policy year.
   e. The length of each segment is determined by the contract segmentation method.
   f. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.
   g. For both basic reserves and deficiency reserves computed by the contract segmentation method, present values shall include future benefits and net premiums in the current segment and in all later segments.
10. "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.
11. "Ten-year select factors" mean the select factors adopted by the NAIC with the 1980 amendments to the NAIC Standard Valuation Law set forth at A.R.S. § 20-510.
12. "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, when:
    a. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and
    b. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, when the uniform percentage is such that, at the date of issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of (i) over (ii), as follows:
       i. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium is due. However, the net level annual premium shall not exceed the net level annual premium on a 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one-year higher than the age at issue of the policy.
       ii. A net one-year term premium for the benefits provided in the first policy year.
    c. The interest rates used in the present value calculations for any policy shall not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from the date of issue to the mandatory expiration of the policy.
12. "Universal life insurance policy" means an individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

R20-6-309.01. Applicability

A. General Scope. R20-6-309 through R20-6-309.04 apply to all life insurance policies with or without nonforfeiture values, issued on or after the effective date of this rule, subject to the exceptions and conditions in this Section.

B. Exceptions. R20-6-309 through R20-6-309.04 do not apply to policies listed in this subsection.

1. An individual life insurance policy that is issued in accordance with and as a result of the exercise of a reentry provision in an original life insurance policy that:
   a. Has the same or a greater face amount,
   b. Was issued before the effective date of this rule, and
   c. Guarantees the premium rates of the new policy.
2. An individual life insurance policy subsequently issued under a derivation of a reentry provision, as described in subsection (B)(1).
3. A universal life policy that meets all the following requirements:
   a. Any secondary guarantee period in the policy is five years or less;
   b. The specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables in R20-6-309.01(7) and the applicable valuation interest rate; and
   c. The initial surrender charge is not less than 100% of the first year annualized specified premium for the secondary guarantee period.
4. A variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts established in accordance with A.R.S. § 20-651.
5. A variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts established in accordance with A.R.S. § 20-651.
6. A group life insurance certificate unless the certificate has a stated or implied schedule of maximum gross premiums required to continue coverage in force for a period in excess of one year.

C. Conditions.
1. An insurer shall calculate the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, as specified in R20-6-309.03.
2. An insurer shall calculate the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that allow a policyholder to keep a policy in force during a secondary guarantee period as provided in R20-6-309.04.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

R20-6-309.02. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves

A. For any one or more specified plans of life insurance, an insurer may elect to calculate the minimum mortality standard for basic reserves using the 1980 CSO valuation tables with select mortality factors. If the insurer elects to use select mortality factors, the insurer may use:
1. The 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; or
2. The select mortality factors in Appendix A;

B. An insurer shall calculate deficiency reserves, if any, for each policy as the excess, if greater than 0, of the quantity A over the basic reserve. Quantity A is obtained by recalculating the basic reserve for a policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. For any one or more specified plans of insurance, an insurer may elect to base the quantity A and the corresponding net premiums used in the determination of quantity A on the 1980 CSO valuation tables with select mortality factors. If the insurer elects to use select mortality factors, the insurer may use:
1. The 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;
2. The select mortality factors in Appendix A; or
3. For durations in the first segment, X% of the select mortality factors in Appendix A, subject to all the following conditions:
   a. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;
   b. X shall not be less than 20%;
   c. X shall not decrease in any successive policy years;
   d. X is such that, when using the valuation interest rate for basic reserves, (i) is greater than or equal to (ii):
      i. The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;
      ii. The actuarial present value of future death benefits, calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date.
   e. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date.
   f. The insurer's appointed actuary shall increase X at any valuation date when it is necessary to continue to meet all the requirements of subsection (B)(3).
   g. The insurer's appointed actuary may decrease X at any valuation date if X does not decrease in any successive policy years and continues to meet all the requirements of subsection (B)(3).
   h. The insurer's appointed actuary shall take into account the adverse effect on expected mortality and lapsing of any anticipated or actual increase in gross premiums.
   i. If X is less than 100% at any duration for any policy, the insurer shall meet the requirements in this subsection.
      i. The insurer's appointed actuary shall annually prepare an actuarial opinion and memorandum as required by A.R.S. §§ 20-696.04 and 20-510 et seq.
      ii. The insurer's appointed actuary shall annually opine for all policies subject to R20-6-309 through R20-6-309.04 as to whether the mortality rates resulting from the application of X meet the requirements of subsection (B)(3).
      iii. The actuary shall support the opinions described in subsections (B)(3)(i)(i) and (B)(3)(i)(ii) by an actuarial report, subject to Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.
      iv. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

C. This Section applies to both basic reserves and deficiency reserves. An insurer may use any set of select mortality factors for only the first segment, except that if the first segment of the

policy is less than 10 years, the insurer shall use the appropriate 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law through the 10th policy year from the date of issue.

D. To determine basic reserves or deficiency reserves, an insurer may use guaranteed gross premiums without policy fees if the calculation involves the guaranteed gross premium, but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, the insurer may include policy fees in guaranteed gross premiums, even if those fees are not included in the actual calculation of basic reserves.

E. An insurer shall calculate reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits, that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change as the greatest of the following:

1. Reserves calculated without regard to the guarantee,
2. Reserves assuming the guarantee was made at date of issue, and
3. Reserves assuming that the policy was issued on the date of the guarantee.

F. The Director may require the insurer to document the extent of the adequacy of reserves for specified blocks of business, including policies issued before the effective date of this rule. This documentation may include a demonstration of the extent to which the insurer has relied upon aggregation with other non-specified blocks of business to form the appointed actuary's opinion under A.R.S. §§ 20-510 and 20-696.07.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

R20-6-309.03. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)

A. Basic Reserves.

An insurer shall calculate basic reserves as the greater of the segmented reserves and the unitary reserves. The insurer shall use the same valuation mortality table and selection factors for both the segmented reserves and the unitary reserves for any policy. To calculate segmented reserves and net premiums, the insurer may elect one of the following adjustments:

1. Treat the unitary reserve, if greater than 0, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than 0, applicable at the beginning of each segment, from the present value of guaranteed life insurance and endowment benefits for each segment; or
2. Treat the guaranteed cash surrender value, if greater than 0, applicable at the end of each segment as a pure endowment, and subtract the guaranteed cash surrender value, if greater than 0, applicable at the beginning of each segment, from the present value of guaranteed life insurance and endowment benefits for each segment.

B. Deficiency Reserves.

1. An insurer shall calculate the deficiency reserve at any duration on the following basis:
   a. A unitary basis if the corresponding basic reserve determined by subsection (A) is unitary;
   b. A segmented basis if the corresponding basic reserve determined by subsection (A) is segmented; or
   c. The segmented basis if the corresponding basic reserve determined by subsection (A) is equal to both the segmented reserve and the unitary reserve.
2. Subsection (B) applies to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality specified in R20-6-309.02 (B) and the valuation rate of interest.
3. An insurer shall calculate deficiency reserves, if any, for each policy as the excess if greater than 0, for the current and all remaining periods, of the quantity A over the basic reserve, when A is obtained as indicated in R20-6-309.02(B).
4. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

C. Minimum Value.

Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if an insurer uses mean reserves. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves if the insurer uses select mortality factors, the insurer shall use the 10-year select factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law. Total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) shall not be less than the amount that the policy owner would receive upon termination of the policy.

D. Unusual Pattern of Guaranteed Cash Surrender Values.

1. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held before the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, when *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.
2. The reserves actually held after any unusual guaranteed cash surrender value accrues shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, when:
   a. At the valuation date, *n* is the number of years from the date of the last unusual guaranteed cash surrender value, to the earlier of:
      i. The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or
      ii. The mandatory expiration date of the policy; and
   b. The net premium for a given year during the *n* year period is equal to the product of the net-to-gross ratio and the respective gross premium; and
   c. The net-to-gross ratio is equal to (i) divided by (ii) as follows:

i. The present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the *n* year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period.

ii. At the beginning of the *n* year period, the present value of the scheduled gross premiums payable during the *n* year period.

3. In this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:
   a. 110% of the scheduled gross premium for that year;
   b. 110% of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and
   c. 5% of the first policy year surrender charge, if any.

E. Optional Exemption for Yearly Renewable Term Reinsurance ("YRT"). An insurer may elect the approach with the criteria listed in this subsection for reserves on YRT reinsurance:
1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.
2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (C).
3. Deficiency reserves.
   a. For each policy year, calculate the excess, if greater than 0, of the valuation net premium over the respective maximum guaranteed gross premium.
   b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subsection (E)(3)(a).
4. For calculations under subsection (E), the insurer shall use the maximum valuation interest rate and the 1980 CSO mortality tables with or without 10-year select mortality factors.
5. In subsection (E) a reinsurance agreement is deemed YRT reinsurance if only the mortality risk is reinsured.
6. If the reinsurer chooses the optional exemption under subsection (E), the ceding insurer's reinsurance reserve credit is limited to the amount of reserve the reinsurer holds for the affected policies.

F. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. An insurer may elect the approach with the criteria listed in this subsection for reserves for attained-age-based YRT life insurance policies:
1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.
2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (C).
3. Deficiency reserves.
   a. For each policy year, calculate the excess, if greater than 0, of the valuation net premium over the respective maximum guaranteed gross premium.
   b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subsection (F)(3)(a).
4. For calculations under subsection (F), the insurer shall use the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10-year select mortality factors.
5. In subsection (F), a policy is deemed an attained-age-based YRT life insurance policy if, on both the initial current premium scale and the guaranteed maximum premium scale:
   a. The premium rates are based on the attained age of the insured such that the rate for any given policy at a given attained age of the insured, is independent of the year the policy was issued; and
   b. The premium rates are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance, and attained age.
6. For policies that become attained-age-based YRT policies after an initial period of coverage, an insurer may use the approach in subsection (F) after the initial period if:
   a. The initial period is constant for all insureds of the same sex, risk class, and plan of insurance; or
   b. The initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and
   c. After the initial period of coverage, the policy meets the condition subsection(F)(5).
7. If the insurer elects the approach under subsection (F), the insurer shall use this approach in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this rule.

G. Exemption from Unitary Reserves for Certain *n*-Year Renewable Term Life Insurance Polices. An insurer that meets the following conditions is not required to calculate unitary basic reserves and unitary deficiency reserves for a policy:
1. The policy consists of a series of *n*-year periods, including the first period and all renewal periods, when *n* is the same for each period, except that for the final renewal period, *n* may be truncated or extended to reach the expiration age, if:
   a. The final renewal period is fewer than 10 years and fewer than twice the number of the earlier *n*-year periods; and
   b. For each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;
2. The guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based on the 1980 CSO Table with or without the 10-year select mortality factors; and
3. There are no cash surrender values in any policy year.

H. Exemption from Unitary Reserves for Certain Juvenile Policies.

An insurer that meets the following conditions is not required to calculate unitary basic reserves and unitary deficiency reserves for a policy based upon the initial current premium scale if at date of issue:
1. The insured is age 24 or younger;
2. Until the insured reaches the end of the juvenile period, which shall occur at or before age 25, the gross premiums and death benefits are level, and there are no cash surrender values; and
3. After the end of the juvenile period, gross premiums are level for the remainder of the premium-paying period, and death benefits are level for the remainder of the life of the policy.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

R20-6-309.04. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period

A. General.
1. A policy is deemed to have a secondary guarantee if it meets one or more of the following criteria:
   a. The policy is guaranteed to remain in force at the original schedule of benefits, subject only to the payment of specified premiums; or
   b. For any duration, the minimum premium is less than the corresponding one-year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10-year select mortality factors.
2. A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. If a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at the valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after the date of issue are deemed to have been made at issue. An insurer shall recalculate reserves described in subsections (B) and (C) from date of issue to reflect the insurer's changes.
3. Specified premiums mean the premiums specified in the policy, that, if paid guarantee that the policy will remain in force at the original schedule of benefits, but which are otherwise insufficient to keep the policy in force if the insurer imposes maximum mortality and expense charges and minimum interest credits, and assesses any applicable surrender charges.
4. In subsection (A), the minimum premium for any policy year is the premium that, when paid into a policy with a 0 account value at the beginning of the policy year, produces a 0 account value at the end of the policy year. To calculate the minimum premium the insurer shall use the policy cost factors (including mortality charges, loads, and expense charges) and the interest-crediting rate, which are all guaranteed at date of issue.
5. The one-year valuation premium means the net one-year premium based on the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. An insurer shall not use the select mortality factors defined in R20-6-309.02(B)(2) and (3) to calculate the one-year valuation premiums.
6. The one-year valuation premium shall reflect the frequency of fund processing, as well as the distribution of deaths assumption used to calculate the monthly mortality charges to the fund.

B. Basic Reserves for the Secondary Guarantees.
An insurer shall use the segmented reserves for the secondary guarantee period as the basic reserves for the secondary guarantees. In calculating the segments and the segmented reserves, the insurer shall set gross premiums equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and determine the segments under the contract segmentation method in R20-6-309(2).

C. Deficiency Reserves for the Secondary Guarantees.
An insurer shall calculate deficiency reserves, if any, for the secondary guarantees for the secondary guarantee period, as described in R20-6-309.03(B) with gross premiums set equal to the specified premiums, if any, or to the minimum premiums that keep the policy in force.

D. Minimum Reserves.
The minimum reserves during the secondary guarantee period are the greater of:
1. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or
2. The minimum reserves required under Arizona law governing universal life plans.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

Appendix A. Select Mortality Factors

This appendix contains tables of select mortality factors that are the bases to which the respective percentages of R20-6-309.02(A)(2), (B)(2), and (B)(3) are applied.

The 6 tables of select mortality factors include: (1) male aggregate, (2) male non-smoker, (3) male smoker, (4) female aggregate, (5) female non-smoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.
For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are 80% of the appropriate male table in this Appendix, plus 20% of the appropriate female table in this Appendix.

Table 1. Male Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100

Issue **Duration**

Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 2. Male, Non-smoker

Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Issue **Duration**

Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 3. Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100

Issue **Duration**

Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Issue **Duration**

Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 4. Female, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Issue **Duration**

Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 5. Female, Non-smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100

Issue **Duration**

Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 6. Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Historical Note
Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4).

ARTICLE 4. TYPES OF INSURANCE COMPANIES

R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers

A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-40, Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with the Office of the Secretary of State and available from the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation."

B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

Historical Note
Former General Rule 57-3. R20-6-401 recodified from R4-14-401 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3). New Section made by final rulemaking at 9 A.A.R. 1086, effective March 6, 2003 (Supp. 03-1).

R20-6-402. Expired

Historical Note
Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit A. Expired

Historical Note
Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit B. Expired

Historical Note
Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-403. Expired

Historical Note
Former General Rule 69-21. R20-6-403 recodified from R4-14-403 (Supp. 95-1). Section expired under A.R.S. §

41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix A. Expired

Historical Note

R20-6-403, Appendix A recodified from R4-14-403, Appendix A (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix B. Expired

Historical Note

R20-6-403, Appendix B recodified from R4-14-403, Appendix B (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix C. Expired

Historical Note

R20-6-403, Appendix C recodified from R4-14-403, Appendix C (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-404. Repealed

Historical Note

Former General Rule 73-31; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-404 recodified from R4-14-404 (Supp. 95-1).

R20-6-405. Health Care Services Organization

A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-106 and 20-1051 through 20-1068.

B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 128, Laws of 1973, to regulate and control Health Care Services Organizations in the State of Arizona, (including, but not limited to Certificate of Authority, licensing, fees for licensing, disciplinary procedures for agents and control of solicitation of members and evidences of coverage).

C. Scope

1. The scope of this Rule is the scope of A.R.S. Title 20 as it relates to Insurers or Hospital or Medical Service Corporations. As it relates to Health Care Services Organizations, the scope of this rule is the scope of Title 20, Chapter 1 and Title 20, Chapter 4, Article 9, as provided in A.R.S. § 20-1068. This rule is applicable to agents of persons, and persons operating or proposing to operate Health Care Services Organizations in the State of Arizona.
2. The statutory authority for this rule, A.R.S. Title 20, Chapter 4, Article 9, does not provide for exemptions therefrom for persons or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.

D. Repeal. This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.

E. Definitions. As used in this rule, unless the context otherwise requires:

1. "Agent" has the meaning of A.R.S. § 20-282.
2. "Basic Health Care Services" has the meaning of A.R.S. § 20-1051.
3. "Certificate of Authority" means a Certificate authorizing operation of a Health Care Services Organization.
4. "Director" means the Director of Insurance of the State of Arizona.
5. "Enrollee" has the meaning of A.R.S. § 20-1051.
6. "Evidence of coverage" has the meaning of A.R.S. § 20-1051.
7. "Health Care Plan" has the meaning of A.R.S. § 20-1051.
8. "Health Care Services" has the meaning of A.R.S. § 20-1051.
9. "Health Care Services Organizations" has the meaning of A.R.S. § 20-1051.
10. "Hospital Service Corporation" has the meaning of A.R.S. § 20-822.
11. "Insurer" has the meaning of A.R.S. § 20-106(C).
12. "License" means the authority to act as an agent of a Health Care Services Organization.
13. "Medical Service Corporation" has the meaning of A.R.S. § 20-822.
14. "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.
15. "Person" has the meaning of A.R.S. § 20-1051.
16. "Physician and patient relationship" has the meaning of A.R.S. § 20-833.
17. "Prepaid Health Plans" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.
18. "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.
19. "Provider" has the meaning of A.R.S. § 20-1051.
20. "Transact" has the meaning of A.R.S. § 20-106(A) and (B).
21. "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.

F. Certificate of Authority

1. Policy. Persons and agents of persons operating Health Care Services Organizations as of May 7, 1973, shall comply with the application requirements of A.R.S. § 20-1052 on or before August 7, 1973.
2. A Certificate of Authority shall not be granted until the Director is satisfied that the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
3. An examination of an applicant at the expense of the applicant for a Certificate of Authority may be ordered to be made if the applicant is not a resident, is controlled by a non-resident, or maintains a head or principal office out of its service area, and will be ordered to be made if the applicant contracts with providers, or for services outside a reasonable area, or has contract obligations under its evidence of coverage that are, or appear to be, inequitable or unreasonable as to the enrollees.

G. Certificate of Authority – Application

1. A person required to be qualified to do business in this State as a Health Care Services Organization, pursuant to A.R.S. § 20-1052 shall file an application for Certificate of Authority on Department Form E-104.
2. Applications failing to comply with the requirements of A.R.S. § 20-1053 will be denied without prejudice to the filing of an application complying with such requirements.
3. Health Care Services Organizations operating in this State as of May 7, 1973, and having submitted a sufficient application for Certificate of Authority as required

by this rule, including the disclosure filings of paragraph (7) of this subsection, may continue to operate as an organization until the Director acts upon the application.

4. The application for Certificate of Authority shall be verified by an authorized and qualified officer of the Health Care Services Organization.
5. The application for Certificate of Authority shall be accompanied by the fees required for a hospital or medical service corporation by A.R.S. § 20-167 and a tax return or returns on Department Form E-162, for the calendar year previous to the calendar year of application during which the applicant has done business in this State as a Health Care Services Organization, and the amount of tax due thereon after the effective date hereof, if any, as provided by A.R.S. § 20-1060. The filing of such returns or payment of such tax may be adjusted or waived by the Director upon application and affirmative showing in writing therefor justifying the adjustment or waiver.
6. The Director may, upon written request accompanied by supporting documentation justifying the request, authorize the substitution of public information filed by an applicant under similar statutes or regulations in another state, or under federal requirements, or may waive such information or additional information.
7. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions or principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.
8. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.

H. Certificate of Authority – Application. The application for Certificate of Authority shall be accompanied by a power of attorney as required by A.R.S. § 20-1053(A)(10) on Department Form E-128.

I. Certificate of Authority – Grounds for denial

1. Policy. A Certificate of Authority to operate a Health Care Services Organization shall not be granted until the Director is satisfied by the affirmative showing, verified by the applicant, that all of the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
2. Guidelines. The guidelines and standards for determination of appropriate mechanisms to achieve an effective Health Care Plan include, but are not limited to the following:
   a. Ability to provide basic Health Care Services without undue restrictions, limitations, discrimination, unreasonable fee schedules, or unreasonable administrative costs; an affirmative showing that the form of organization does not evidence any coercion, duress or other compulsion over members;
   b. The form of organization does not lend itself to practices prohibited by A.R.S. §§ 20-441 through 20-459, and
   c. The evidence of coverage does not contain provisions or statements which are unjust, inequitable, misleading, deceptive or untrue or encourage mispresentation.
3. Failure to pay obligations. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected if the applicant has failed after 30 days from the entry of final judgment, to pay obligations within the provisions of an evidence of coverage issued by such applicant. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action or appealing a judgment at law or equity in a court of this state, or is required to obtain a Certificate of Authority so as to maintain such action.
4. Unauthorized agents. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected, after stated cause and opportunity to answer, if the applicant has, 90 days after the effective date, permitted transactions by an unauthorized agent.

J. Solicitation requirements

1. Forms for evidences of coverage, advertising matter, sales material and amendments thereto, will not be approved until the Director is satisfied by filing of Department Form P-107 accompanying the filing of such form and the payment of necessary fees, that the requirements of A.R.S. §§ 20-1057, 20-1054(2), and 20-1061 have been met and will continue to be met.
2. Each Health Care Services Organization shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement brochure, form letter of solicitation, evidence of coverage, certificate, agreement or contract, and a copy of all radio and television forms of the above hereafter disseminated in this or any other State with a notation attached to each such solicitation or inducement to indicate the manner and extent of distribution and the date of approval by the Department of such solicitation. Such advertising file shall be maintained for a period of not less than three years.

K. Annual report. Each Health Care Services Organization required to file an annual statement, shall, on or before March 1 of each year, file with the Director, together with its annual statement on Department Form E-13, a certificate executed by an authorized officer of the Health Care Services Organization stating that to the best of his knowledge, information and belief, all written solicitations disseminated during the preceding statement year complied or were made to comply with the provisions of Title 20, Chapter 4, Article 9, and this rule, and that no forms of solicitation were disseminated without the prior approval of the Director.

L. Taxes

1. All Health Care Services Organizations operating and transacting business in the State of Arizona shall on or before March 1 and with the filing of the Annual Report, file a tax return on Department Form E-162, and pay the tax due on such return pursuant to A.R.S. § 20-1060.
2. A tax return required to be filed and filed with an application for Certificate of Authority may cover a period of time of less than a calendar year as specified in the return and approved by the Director. Annual tax returns required to be filed coincident with the annual report shall be for the full calendar year next preceding the date of filing the annual report.
3. Net charges, as in this rule defined, shall represent the net charges received during the calendar year next preceding the date of filing the annual report and tax return.

M. Deposit requirements

1. In the event a Health Care Services Organization determines to maintain statutory deposits by a surety bond, such surety bond shall be in form as approved by the

Director guaranteeing the payment of Health Care Services furnished to enrollees, and shall be deposited with the State Treasurer.

2. In the event a Health Care Services Organization determines to maintain the deposit requirements by filing securities with the State Treasurer, a full and complete statement of the securities proposed to be deposited, together with sufficient information to permit a determination of eligibility of such securities shall be filed with the Director on Department Form E-123, and such securities shall not be deposited until such securities are approved by the Director in writing.
3. No securities deposited as herein provided shall be exchanged or substituted for similar securities, except upon the prior written approval of the Director.
4. Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(f) shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.
5. Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage shall have been paid and the Director has given his authority in writing to withdraw such deposits or cancel such bonds.

N. Reserve requirements. Reserves required by A.R.S. § 20-1056 shall be deposited or maintained as cash, as Certificates of Deposit, or as securities eligible for investment of the capital of domestic insurers, pursuant to A.R.S. §§ 20-537 and 20-538.

O. Insurers and hospital and medical service corporations – Certificate of Authority

1. Insurers, Hospital Service Corporation, Medical Service Corporations, and Hospital and Medical Service Corporations, holding current Certificates of Authority to do business in this state may organize and operate Health Care Services Organizations jointly or severally without compliance with the deposit and reserve requirements of the statute, if the application contains an affirmative showing that the applicant organization has complied with comparable provisions of Title 20, and is an appropriate mechanism to achieve an effective Health Care Plan.
2. The provisions of statute and this rule applying to Certificates of Authority and Application therefor, shall apply to all insurers, Hospital Service Corporations, Medical Service Corporations, and Hospital and Medical Service Corporations doing business in this state.
3. Organizations claiming exemption or partial exemption pursuant to A.R.S. § 20-1063(c) shall file with the Director simultaneously with the application for Certificate of Authority, a statement affirmatively showing that the applicant has complied with provisions of Title 20 A.R.S. comparable to or more restrictive than the provisions of Title 20, Chapter 4, Article 9, and shall have received the written approval of the Director for such exemption or partial exemption.

P. Application, examination and licensing of agents

1. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization, unless, prior to making any solicitation or transaction, he has been appointed agent by a Health Care Services Organization holding a current valid Certificate of Authority and has been licensed as herein provided. Persons directly or indirectly representing or acting for a Health Care Services Organization and not licensed as herein provided, or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.
2. Any person applying for a license as an agent of a Health Care Services Organization shall do so by filing with the Department of Insurance the following:
   a. An application for such license on a form approved by the Director of the Department of Insurance;
   b. The required fees for such license;
   c. Such additional information as the Director may deem necessary.
3. The licensing of an agent of a Health Care Services Organization shall not become effective until such applicant shall have satisfactorily passed a written examination in accordance with A.R.S. § 20-292 as supplemented by A.R.S. § 20-167.
4. The examination shall be given in such places and at such times as the Director shall from time to time designate.
5. The form of examination and the manual may be altered and amended from time to time, so as to represent a fair test of the applicant's qualifications.
6. Every applicant for license shall satisfactorily complete the examination given with a grade of at least 70%, or such other percentage as may be fixed from time to time by the Director prior to the examination commensurate with the nature of the examination given.
7. License and examination fees shall be in accordance with A.R.S. § 20-167.
8. Report of the results of any examination given pursuant to this rule shall be mailed to the applicant and to the applicant's Health Care Services Organization at the address shown on the application.
9. Except as modified by this rule, the provisions for examination, licensing, annual fees and disciplinary procedures of Chapter 2, Article 3 of Title 20, shall apply.
10. Any agent licensed in this state shall immediately report to the Director any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or other violation affecting his license and all complaints or charges of misconduct lodged with his employer, any public agency of the state, or another state.
11. The Director may reject any application or suspend or revoke, or refuse to renew any agent's license for inducements or statements which are unjust, unfair, inequitable, misleading or deceptive, or which encourage misrepresentation, or are untrue or misleading.
12. The rules, standards and guidelines governing any proceeding relating to the suspension or revocation of the license of a life insurance agent, where applicable, shall also govern any proceedings for suspension or revocation of the license of an agent of a Health Care Services Organization.
13. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.
14. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.

Q. Forms

1. The forms prescribed by this rule and the instructions applicable thereto are adopted as requirements of the Director and necessary for the protection of citizens of this state. Such forms, instructions, manuals or examina-

tions are those currently in use, but the same may be amended without reference to this rule and when approved as amended are incorporated in this rule by reference. The form of manual or examination of agents, or any form adopted by the Director may be reproduced for the purpose of reporting or for other purposes.

2. For good cause shown, the Director may authorize the filing of forms and reports on dates other than required by this rule, if applied for in writing not less than 10 days prior to the due date of such report and statement, exhibit, return or accounting.

R. Severability. In any provision of this rule or the forms, statements, returns or reports made part of this rule, or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions of applications of this rule, which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

S. Effective date. This rule became effective on the 7th day of May, 1973. Amendments to this rule shall become effective upon filing with the Secretary of State.

Historical Note

Former General Rule 73-33; Amended subsections (E), (P), (R), (S), and (T) effective August 12, 1981 (Supp. 81-4). R20-6-405 recodified from R4-14-405 (Supp. 95-1).

R20-6-406. Expired

Historical Note

Adopted effective May 18, 1978 (Supp. 78-3). R20-6-406 recodified from R4-14-406 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-407. Service Companies

A. Scope. This rule shall apply to all service companies except those which are exempt under A.R.S. § 20-1095.02.

B. Definitions.

1. "Gray Market" auto means an imported motor vehicle which has not been certified for all safety, emission, and other federal and state standards prior to the arrival of the vehicle into the United States.
2. "Service" within the meaning of Article 11, Chapter 4, Title 20 includes:
   a. Reimbursement for towing, car rental, lodging or travel breakdown expenses.
3. The "Contract Holder" means the consumer as defined in A.R.S. § 20-1095(1).

C. Application for service company permit.

1. The application for a service company permit under this rule shall be on the form designated by the director which shall contain the following information:
   a. The name of applicant;
   b. Arizona address of applicant;
   c. The home office address of applicant;
   d. Type of entity (e.g. corporation, partnership);
   e. Type of equipment to be serviced;
   f. Fiscal year of applicant;
   g. A list of suspensions, revocations or other disciplinary or rehabilitative actions against the service company in this or any other jurisdiction.

   The application form shall be signed under oath and acknowledged by the chief executive officer, chairman of the board of directors, or other person having power of attorney, in which case the power of attorney shall be attached.
2. The following items shall be attached to the application form and shall complete the application:
   a. A copy of the service company's most recent financial statement, sworn to and certified by the owner, duly elected officers, or a certified public accountant.
   b. Evidence of having deposited cash or acceptable securities pursuant to A.R.S. § 20-1095.04.
   c. Surety bond in lieu of deposit under subparagraph (b) on a form acceptable to the Director.
   d. Initial nonrefundable permit fee of $100 with each new application.
   e. A biographical affidavit, on a form approved by the director, for each officer, director, manager or person owning 25% or more of the service company, and for each officer, director, manager or person owning 25% or more of an entity which owns the service company.
   f. A copy of the service company's service contract, application, claim forms, brochures, and other forms used in connection with the sale.

D. Deposit.

1. A service company providing a deposit of cash or alternatives to cash pursuant to A.R.S. § 20-1095.04 shall maintain the deposit in the amount required and such deposit shall not be encumbered. The deposit shall not be released except pursuant to one of the following:
   a. The service company provides a bond or mechanical reimbursement policy which covers the outstanding service contract liabilities.
   b. All outstanding service contracts and liabilities thereunder have been assumed by a service company, in good standing, with the approval of the director, acknowledged by the assuming service company's administrator and acknowledged by endorsement by the mechanical reimbursement insurer or surety.
   c. Evidence satisfactory to the director that
      i. All outstanding service contracts and liabilities have expired or been cancelled in accordance with the service contract terms,
      ii. That all claims have been settled,
      iii. That there is no reason to believe there are any unreported claims, and
      iv. That the service company is financially able and agrees to be financially responsible for any valid unreported claims.

E. The service contract, approval of forms.

1. Each service company holding a service company permit or applying for such permit shall submit all contract, claim and application forms, brochures and other advertising material to the Director for approval not less than 30 days prior to the proposed effective date thereof. No form, brochure or other printed material may be used until approved by the Director or has been on file with the Director more than 30 days.
2. No service contract shall be approved unless it contains a provision permitting the cancellation of the contract. The cancellation provision shall provide for a pro rata refund after deducting for administrative expenses associated with the cancellation. No claim incurred or paid shall be deducted from the amount to be returned. The cancellation provision shall not contain both cancellation penalty and a cancellation fee.
3. No service contract or application shall be approved unless it:

a. Is written in nontechnical, readily understood language, using words with common everyday meanings;
b. Provides for the performance of services within a reasonable period of time of the request for such services by the holder of the contract;
c. Discloses on the face of the application and the contract:
(i) The name, address and telephone number of the service company;
(ii) The name, address and telephone number of the service contract administrator, if any;
(iii) The name of the individual who sold the service contract.
d. Clearly, conspicuously and plainly states:
(i) The services to be performed by the service company and the terms and conditions of such performance;
(ii) The service fee or deductible charge, if any, to be charged, or applied, for service calls and/or each covered repair.
(iii) Each of the systems, products, appliances and components covered by the contract;
(iv) The period during which the contract will remain in effect;
(v) All limitations respecting the performance of services, including any restrictions as to time periods when services may be required or will be performed;
(vi) The cost of the service contract;
(vii) Those specific items or components which are excluded from coverage in large bold type;
(viii) The conditions, if any, under which the service contract or coverage may be reinstated after coverage has been voided by acts or omissions by the service contract holder;
(ix) The material acts or omissions by the contract holder which cancel or void coverage;

4. No service contract shall be approved if:
a. The coverage may be cancelled or voided due to acts or omissions of the service company, its assignees or subcontractors for their failure to provide correct information of their failure to perform the services or repairs provided in a timely, competent, workmanlike manner;
b. Parts or components repaired or replaced under the service contract are excluded;
c. The contract can be cancelled or voided by the service company or its representatives for the following reasons including but not limited to:
i. Pre-existing conditions;
ii. Prior use or unlawful acts relating to the product;
iii. Misrepresentation by either the service company or its subcontractors;
iv. Ineligibility for the program, including gray market, high performance and GM diesel autos.

F. Disapproval of contracts, applications or advertising. The director may disapprove any service contract, application or advertising material that is in violation of this rule by issuing an order specifying in what respect the service contract, application or advertising material violates this rule. Any person aggrieved by such an order can demand a hearing thereon in accordance with A.R.S. § 20-1095.09.

G. Permit expiration; renewal.

1. Each permit issued pursuant to this rule shall expire at midnight on the last day of the service company's fiscal year. Thereafter, the service company shall have 90 days in which to file its completed renewal application including its certified financial statement and pay the renewal fee of $100. A permit shall remain in effect upon the service company's timely payment of the renewal fee, timely filing of its annual financial statement and completed renewal application. An incomplete application will not be considered received until it is complete.
2. Any late filing of the renewal application, financial report or late payment of the renewal fee shall be subject to a late fee of $25 per day. Such late fee shall not release the service company of liability for other violations of these rules or other laws.

Historical Note

Adopted effective April 30, 1981 (Supp. 81-2). Former Section R4-14-407 repealed and a new Section R4-14-407 adopted effective July 2, 1987 (Supp. 87-3). R20-6-407 recodified from R4-14-407 (Supp. 95-1).

R20-6-408. Motor Vehicle Service Contract Program

A. Scope. This rule shall apply to all motor vehicle service contract programs as defined in A.R.S. § 20-1095(5).

B. Definitions.
1. "Gray Market" auto means an automobile which has not been certified for all safety, emission, and other federal and state standards prior to the arrival of the vehicle into the United States.
2. "Service" within the meaning of Article 11, Chapter 4, Title 20 includes:
a. Reimbursement for towing, car rental, lodging or travel breakdown expenses.
3. The "Contract Holder" means the consumer as defined in A.R.S. § 20-1095(1).

C. Application for motor vehicle service contract program.
1. The application for approval of a motor vehicle service contract program under this rule shall be on the form designated by the director which shall contain the following information:
a. Name of administrator;
b. Arizona address of administrator;
c. Home office of administrator;
d. The type of entity (e.g. corporation, partnership);
e. Whether the administrator is an insurer;
f. The name of the program.
The application form shall be signed under oath and acknowledged by the chief executive officer, chairman of the board of directors, or other natural person having power of attorney to represent the entity, in which case the power of attorney shall be attached to the application.
2. The following items shall be attached to the application form and shall complete the application:
a. Mechanical reimbursement insurance policy with an Arizona endorsement on a form acceptable to the Director, or an Arizona bond on a form acceptable to the Director which will be issued to each dealer or cash or securities deposited with the state treasurer through the Director's office in lieu of the policy or bond.
b. Initial nonrefundable permit fee of $100 with each application. A separate and complete application and fee must be submitted for each service contract form.

c. A list of the dealers who propose to sell the motor vehicle service contract program, if known.
d. The service contract program, including all contract forms, claims forms, applications, brochures, and other forms used in connection with the sale.
e. Biographical affidavits, on a form approved by the Director, for each person owning 25% or more of the administrator or insurer.
f. The name and address of its statutory agent in Arizona for the purpose of service of process.

3. If the administrator or insurer elects to use a mechanical reimbursement insurance policy, then the following applies to meet the requirements of A.R.S. § 20-1095.06(B):
a. An application shall not be submitted before an insurance company has had its rules, rates and forms approved. The insurance company must file the mechanical reimbursement policy forms, rules and rates for approval.
b. The cancellation procedure in the mechanical reimbursement policy, any procedure manual and the service contract shall be consistent.
c. The insurance company shall give insureds 30 days prior notice of any rate revisions to take effect.
d. Mechanical reimbursement policies which void coverage if the dealer, its own authorized repair facility, or its subcontractor provide incorrect or unverifiable information shall not be approved.
e. A mechanical reimbursement policy must be issued by the insurance company to each dealer selling a service contract program.

4. An administrator or an insurer applying for approval pursuant to A.R.S. § 20-1095.06 of a motor vehicle service contract program, which is insured by a mechanical reimbursement policy or surety bond, shall certify that the policy or surety bond is effective prior to the sale of contracts by the dealer.

5. In the event that a surety bond, cash or securities are used to meet the requirements of A.R.S. § 20-1095.06(B), the administrator or insurer shall file with the Director within 90 days after the end of the motor vehicle dealer's accounting year a report stating the number of contracts in force at the end of the year and that the surety bond, cash or securities has been increased as required by A.R.S. § 20-1095.06.

D. Approval of forms.

1. Each administrator or insurer applying for approval of its motor vehicle service contract program, or amendment thereof, shall submit all contract, claim, and application forms, brochures and other advertising material to the Director for approval not less than 30 days prior to the proposed effective date thereof. No form, brochure or other printed material may be used until approved by the Director or has been on file with the Director more than 30 days.

2. No service contract shall be approved unless it contains a provision permitting the cancellation of the contract. The cancellation provision shall provide for a pro rata refund after deducting for administrative expenses associated with the cancellation. No claim incurred or paid shall be deducted from the amount to be returned. The cancellation provision shall not contain both a cancellation penalty and a cancellation fee.

3. No service contract or application shall be approved unless it:
a. Is written in nontechnical, readily understood language, using words with common everyday meanings;
b. Provides for the performance of services within a reasonable period of time of the request for such services by the holder of the contract;
c. Discloses on the face of the application and the contract:
(i) The name, address and telephone number of the motor vehicle dealer, if any;
(ii) The name, address and telephone number of the contract administrator, if any;
(iii) The name of the individual who sold the service contract.
d. Clearly, conspicuously and plainly states:
(i) The services to be performed by the motor vehicle dealer and the terms and conditions of such performance;
(ii) The service fee or deductible charge, if any, to be charged, or applied, for each covered repair;
(iii) Each of the systems and components covered by the contract;
(iv) The period during which the contract will remain in effect;
(v) All limitations respecting the performance of services, including any restrictions as to time periods when services may be required or will be performed;
(vi) The cost of the service contract;
(vii) Those specific items or components which are excluded from coverage in large bold type;
(viii) The conditions, if any, under which the service contract or coverage may be reinstated after coverage has been voided by acts or omissions by the service contract holder;
(ix) The material acts or omissions by the contract holder which cancel or void coverage;

4. No service contract shall be approved if:
a. The coverage may be cancelled or voided due to acts or omissions of the motor vehicle dealer, its assignees or subcontractors for their failure to provide correct information or their failure to perform the services or repairs promised in a timely, competent, and workmanlike manner;
b. Parts or components repaired or replaced under the service contract are excluded;
c. The contract can be cancelled or voided by the administrator, insurer or its representatives for reasons which are within the knowledge and/or control of the motor vehicle dealer including but not limited to:
i. Pre-existing conditions;
ii. Prior use or the odometer has been tampered with prior to purchase;
iii. Misrepresentation by either the motor vehicle dealer or its subcontractors;
iv. Ineligibility for the program, including gray market, high performance and GM diesel autos.

E. Disapproval of contracts, applications or advertising. The director may refuse to approve or disapprove program or advertising material that is in violation of this Rule by issuing an order specifying in what respect the motor vehicle service contract program or advertising material violates this Rule. Any person aggrieved by such an order can demand a hearing thereon in accordance with A.R.S. § 20-1095.09.

F. Motor vehicle dealer's notice of intent.

1. The motor vehicle dealer's notice of intent required by A.R.S. § 20-1095.07(B) shall be certified by an individual having authority to represent the dealer and shall include the following information:
   a. The dealer's name, address and dealer's license number;
   b. The name of the administrator;
   c. The name or other identification of each motor vehicle service contract program which it intends to sell;
   d. The name of the insurer(s), the policy number(s) and the expiration date(s) of its mechanical reimbursement policy or bond;
   e. Confirmation that the dealer will notify the director by certified mail prior to effecting any change in the information provided in its notice of intent. The notice of intent shall be continuous until withdrawn or amended by the motor vehicle dealer.

Historical Note
Former Section R4-14-408 renumbered as Section R4-14-409; a new Section R4-14-408 adopted effective July 15, 1987 (Supp. 87-3). R20-6-408 recodified from R4-14-408 (Supp. 95-1).

R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations

A. Applicability. This rule applies to all subscription contracts issued by hospital, medical, dental and optometric service corporations.

B. Subscription contract provision. Subscription contracts of hospital, medical, dental and optometric service corporations subject to the provisions of Article 3, Chapter 4 of Title 20, A.R.S., shall meet the requirements of the following rules:
1. R20-6-201. Advertisements of disability insurance.
2. R20-6-209. Unfair sex discrimination.
3. R20-6-210. Group coverage discontinuance and replacement.
4. R20-6-213. Unfair discrimination on the basis of blindness, partial blindness, or physical disability.
5. R20-6-216. Life and disability insurance policy language simplification.
6. R20-6-302. Valuation of reserves for disability policies.
7. R20-6-606. Medicare supplement insurance disclosure and minimum standards.
8. R20-6-607. Reasonableness of benefits in relation to premium charged.

C. Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

Historical Note
Adopted effective July 9, 1982 (Supp. 82-4). Former Section R4-14-408 renumbered without change as Section R4-14-409 effective July 15, 1987 (Supp. 87-3). R20-6-409 recodified from R4-14-409 (Supp. 95-1).

ARTICLE 5. THE INSURANCE CONTRACT

R20-6-501. Ten-day Period to Examine Disability Insurance Policy

For the purpose of implementing A.R.S. §§ 20-442, 20-443, 20-826, 20-1111 and 20-1113 and to make more specific the regulation therein provided relative to policies of individual disability insurance (accident and sickness, hospitalization, medical, surgical and loss of time) issued in the State of Arizona and further to provide satisfactory public remedy against the hazards of misunderstanding by an applicant, of deception and coercion by an agent and of certain policy exclusions and limitations that cheapen the value of coverage, the Insurance Department of Arizona adopts the following rule:

1. Each policy of individual disability insurance, except one for which no provision for renewal is made, issued for delivery in the State of Arizona on or after October 1, 1961, by an insurance company or by a hospital or medical service corporation shall have printed on the first page thereof or attached thereto or endorsed thereupon in prominent style a notice declaring that, during a period of 10 days (or, at the insurer's option, a longer period) from the date of delivery to the policyholder, such policy may be returned for cancellation to the insurer at its home office (or, at the insurer's option, to its branch office or to the agent through whom it was purchased) and declaring further that in the event of such return the insurer will refund the entirety of any premium paid therefor, including any policy fees or other charges, and that the policy shall be deemed void from the beginning and that the parties shall be returned to their original position as if no policy had been issued.
2. The Insurance Department does not specify the particular language the notice shall contain but prefers usage of a phraseology approximately along the lines of either the longer (Form A) or shorter (Form B) sample below:

Sample Form A

NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY

The _____Insurance Company urges you to read this policy carefully and trusts that upon doing so you will fully understand, and will be pleased with, its coverage. If, however, questions arise or information is desired, do not hesitate to consult the selling agent. In addition, should the policy for any reason be unsatisfactory, by surrendering it within ten days following receipt to our office at _____ or to the selling agent, immediately full premium will be refunded and the policy will be cancelled and deemed void and as never in force and effect.

Sample Form B

IMPORTANT NOTICE

If for any reason this policy is unsatisfactory, it may be returned for cancellation within ten days following receipt – in which case the entire premium will be refunded.

Historical Note
Former General Rule 61-7. R20-6-501 recodified from R4-14-501 (Supp. 95-1).

ARTICLE 6. TYPES OF INSURANCE CONTRACTS

R20-6-601. Regulations Governing Bail Transactions

A. General provisions
1. Effective date
   a. These regulations are effective November 1, 1960. On and after date, no bail transaction or severable portion thereof shall be conducted, directly or indirectly except in full conformity herewith.
   b. No surety insurer shall furnish for use and no bail bond agent shall use any forms or documents which contain any provisions contrary to these regulations on or after the effective date hereof.
2. Authority. Authority for these regulations is A.R.S. §§ 20-142, 20-143 and 20-257 and A.R.S. Chapter 2, Article 3.
3. Public interest served. These regulations serve the public interest by prohibiting inequities in bail transactions and by establishing standards of licensing and conduct for bail bond agents.
4. Regulations as severable. These regulations shall be construed as severable, such that, where one or more Sections are held invalid, such remaining Sections will not be adversely affected.
5. Penalty. Violation of these regulations will subject the guilty party to the penalties of A.R.S. §§ 20-114, 20-220 and 20-316 and to the enforcement procedures of A.R.S. §§ 20-152 and 20-160 through 20-166.

B. Definitions
1. "Bail transaction" defined. As used in these regulations, the term "bail transaction" includes solicitation and inducement, preliminary negotiation and effectuation of a contract of surety insurance and the transaction of matters subsequent thereto and arising therefrom – all in connection with the release of persons arrested or confined.
2. "Bail bond agent" defined. As used in these regulations, the term "bail bond agent" means any person who engages in a bail transaction on behalf of a surety insurer or representative thereof.
3. "Arrestee" defined. As used in these regulations, the term "arrestee" means any person arrested or detained whose release on bail is solicited or procured or concerning whose release negotiations are commenced.
4. "Director" defined. As used in these regulations, the term "Director" means the Director of Insurance of the state.

C. Licensing
1. Application for license. Each application for original or renewal license as a bail bond agent shall be on a form furnished by the Director, and each applicant for such license shall furnish such supplementary information and supporting statements as the Director may require.
2. Prohibited associations. A bail bond license shall not be issued to, renewed for or maintained by any person who associates regularly with criminals, gamblers or persons of poor repute – except to the extent such association is required by business or professional duty and responsibility.
3. Transactions by unlicensed persons prohibited. No bail bond agent shall directly or indirectly permit any person on his behalf to solicit or negotiate bail transactions unless such person is duly licensed by the Director.
4. Employees. Employees of bail bond agents performing only clerical duties need not be licensed hereunder and shall be deemed not engaged in bail transactions.

D. Conduct of bail bond agents
1. Disclosure of business. Every bail bond agent shall conduct his business in such a manner that the public and those dealing with him shall be aware of the capacity in which he is acting.
2. Control of employees. A bail bond agent shall exercise direct supervision over his employees and keep informed of their actions as his employees.
3. Prohibited employees. No bail bond agent shall have in his employ at any time any criminal, gambler or person of poor repute.
4. Acting for attorney. No bail bond agent shall receive, or collect for an attorney any money or other item of value for attorney's fee, costs or any other purpose on behalf of an arrestee, unless a receipt is given therefor.
5. Informants prohibited. No bail bond agent shall for any purpose, directly or indirectly, enter into an arrangement of any kind or have an understanding with a law enforcement officer, with a newspaper employee, with a messenger service or employee thereof, with a trusty in a jail, with other person incarcerated in a jail, or with any person whatever, to inform or notify any bail bond agent directly or indirectly of:
   a. The existence of a criminal complaint;
   b. The fact of an arrest; or
   c. The fact that an arrest of any person is pending or contemplated; or
   d. Any information pertaining to matters set forth in (a), (b), and (c) hereof or to the persons involved therewith.
6. Compliance with rules of public authority. No bail bond agent shall solicit any person in a bail transaction in a prison or jail or other place of detention, court or public institution connected with the administration of justice unless said bail bond agent has fully complied with every rule, regulation and ordinance issued by each public authority governing the conduct of persons in or about said premises.
7. Representations to public authority
   a. No bail bond agent shall make any misleading or untrue representation to a court or to a public official with respect to a bail transaction, nor for the purpose of avoiding or preventing a forfeiture of bail or of having set aside a forfeiture which has occurred.
   b. Every bail bond agent shall truthfully and fully answer every question asked him by the Director or his representative respecting his bail transactions and matters relating to the conduct of his bail business. Any bail bond agent may have his attorney present when he answers any such question.
8. Maintenance of records. Every bail bond agent shall keep complete records of all business done under authority of his license. Such records shall be open to inspection or examination by the Director or his representatives at all reasonable times at the principal place of business of the bail bond agent as designated in his license.

E. Charges, collateral, refunds and rebates
1. Rates
   a. No bail bond agent shall issue or deliver a bail bond except at the premium rates most recently filed and approved by the Director in accordance with A.R.S. § 20-357.
   b. Every bail bond agent shall post the premium rates of the surety insurer he represents in a conspicuous manner at his place of business.
2. Charges permitted. No bail bond agent shall, in any bail transaction or in connection therewith, directly or indirectly, charge or collect money or other valuable consid-

eration from any person except for the following purposes:
a. To pay the premium at the rates established by the surety insurer and approved by the Director.
b. To provide collateral.
c. To reimburse himself for actual and reasonable expenses incurred in connection with the individual bail transaction, including:
i. Guard fees after the first 12 hours following release of an arrestee on bail;
ii. Notary fees, recording fees, necessary long distance telephone expenses, telegram charges, and travel expenses for other than local community travel.
iii. Any other actual expenditure necessary to the bail transaction which is not usually and customarily incurred in connection with the ordinary operation and conduct of bail transactions.

3. Delivery of documents to arrestee
a. Every bail bond agent shall, at the time of obtaining the release of an arrestee on bail or immediately thereafter, deliver to such arrestee or to the principal person with whom negotiations were made, if other than the arrestee, a copy of the bail bond premium agreement, which shall include:
i. The name of the surety insurer and the name and business address of the bail bond agent.
ii. The amount of bail and the premium thereof.
b. The bail bond agent shall also deliver at such time a statement detailing all charges in addition to the premium, the amount received on account, the unpaid balance if any, and a description of and a receipt for any collateral received.

4. Collateral
a. Any bail bond agent who receives collateral in connection with a bail transaction shall do so in a fiduciary capacity and, prior to any forfeiture of bail, shall keep such collateral separate and apart from any other funds, assets or property of such bail bond agent.
b. Any collateral received shall be returned to the person who deposited it with the bail bond agent or any assignee as soon as the obligation, the satisfaction of which was secured by the collateral, is discharged. Where such collateral has been deposited to secure the obligation of a bond, it shall be returned immediately upon the entry of any order by an authorized official by virtue of which liability under the bond is terminated, or, if any bail bond agent fails to cooperate fully with any authorized official to secure the termination of such liability, immediately upon the accrual of any right to secure an order of termination of liability.
c. When such collateral has been deposited as security for unpaid premium or charges and, if such premium or charges remained unpaid at the time of exoneration and after demand therefor has thereafter been made by the bail bond agent, collateral other than cash may be levied upon in the manner provided by law and cash collateral up to the amount of such unpaid premium on charges may be applied in payment thereof.
d. If collateral received by a bail bond agent is in excess of the bail forfeited, such excess shall be returned to the depositor immediately upon application of the collateral to the forfeiture subject, however, to any claim of the bail bond agent for unpaid premium or charges as provided in subparagraph (c) of paragraph (4) of subsection (E), or as agreed to in writing by the bail bond agent and arrestee or his indemnitor.

5. Premium refund upon surrender of arrestee. No bail bond agent shall surrender an arrestee to custody prior to the time specified in the bail bond for the appearance of the arrestee, or prior to any other occasion when the presence of the arrestee in court is lawfully required, without returning all premium paid therefor, unless as a result of judicial action, or material misrepresentation by the arrestee or his indemnitor with respect to the execution of the bail bond agreement, or a material and substantial increase in the hazard assumed. Failure of the arrestee to pay the premium, or charges permitted under these regulations or any part thereof, and failure to furnish collateral required by the bail bond agent, shall not be considered a material and substantial increase in the hazard assumed.

6. Rebating prohibited. No bail bond agent shall pay or allow in any manner, directly or indirectly, to any person who is not also a bail bond agent any commission or valuable consideration on or in connection with a bail transaction. This Section shall not prohibit payments by a bail bond agent to an unlicensed person of charges by such persons for services of the kind specified in paragraph (2) subsection (E) of this Section.

Historical Note
Former General Rule 60-5. R20-6-601 recodified from R4-14-601 (Supp. 95-1).

R20-6-602. Nationwide Inland Marine Definition

A. Applicability. This rule applies to risks and coverages which may be classified or identified as Marine, Inland Marine or Transportation insurance but shall not be construed to mean that the kinds of risks and coverages are solely Marine, Inland Marine or Transportation insurance in all instances.
This rule shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.

B. Marine and/or transportation policies may cover under the following conditions:
1. Imports.
a. Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.
b. An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:
i. Sold and delivered by the importer, factor or consignee; or
ii. Removed from place of storage and placed on sale as part of the importer's stock in trade at a point of sale or distribution; or
iii. Delivered for manufacture, processing or change in form to premises of the importer or of another for any such purposes.

2. Exports.
a. Exports may be covered wherever the property may be located without restriction as to time, provided

the coverage of each issuing company includes hazards of transportation.

b. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this rule respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.

3. Domestic shipments.
   a. Domestic shipments on consignment, for sale or distribution, exhibit, or trial, or approval or auction, while in transit, while in the custody of others and while being returned, provided the coverage of each issuing company includes hazards of transportation, and further provided that in no event shall the policy cover domestic shipments on consignment on premises owned, leased or operated by the consignor.
   b. Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, and further provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser.
4. Bridges, tunnels and other instrumentalities of transportation and communication excluding buildings, their improvements and betterments, their furniture and furnishings, fixed contents and supplies held in storage. The foregoing includes:
   a. Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.
   b. Piers, wharves, docks, slips, dry docks and marine railways.
   c. Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.
   d. Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.
   e. Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.
   f. Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.
5. Personal Property Floater Risks covering individuals and/or generally
   a. Personal Effects Floater Policies
   b. The Personal Property Floater
   c. Government Service Floater
   d. Personal Fur Floaters
   e. Personal Jewelry Floaters
   f. Wedding Present Floaters for not exceeding 90 days after the date of the wedding.
   g. Silverware Floaters.
   h. Fine Arts Floaters, covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit.
   i. Stamp and Coin Floaters.
   j. Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
   k. Mobile Articles, Machinery and Equipment Floaters, excluding vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use, covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
   l. Installment Sales and Leased Property Policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.
   m. Live Animal Floaters.
6. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation.
   a. Radium Floaters.
   b. Physicians' and Surgeons Instrument Floaters. Such policies may include coverage of such furniture, fixtures and tenant assured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the assured in the practice of his profession.
   c. Pattern and Die Floaters.
   d. Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.
   e. Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.
   f. Salesmen's Samples Floaters.
   g. Exhibition Policies on property while on exhibition and in transit to or from such exhibitions.
   h. Live Animal Floaters.
   i. Builders Risks and/or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.
      i. Such coverage shall be limited to Builders Risks or Installation Risks where Perils in addition to Fire and Extended Coverage are to be insured.
      ii. If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.
   j. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway

use and snow plows constructed exclusively for highway use covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into the custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

k. Property in transit to and from and in custody of bailees not owned, controlled or operated by the bailor. Such policies shall not cover bailee's property at his premises.

l. Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This Section is not intended to include machinery and equipment under certain "lease-back" contracts.

m. Garment Contractors Floaters.

n. Furriers or Fur Storer's Customer's Policies, i.e., policies under which certificates or receipt are issued by furriers or fur storers covering specified articles the property of customers.

o. Accounts Receivable Policies, Valuable Papers and Records Policies.

p. Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

i. Such merchandise is specifically identifiable as encumbered to the bank or lending institution.

ii. The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.

iii. That such policies cover in transit and do not extend beyond the termination of the dealer's interest.

iv. That such policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

q. Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.

r. Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.

s. Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under Inland Marine Policies including:

i. Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

ii. Camera Dealers Policies, covering property consisting principally of cameras and their accessories.

iii. Furrier's Dealers Policies, covering property consisting principally of furs and fur garments.

iv. Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.

v. Stamp and Coin Dealers covering property of philatelic and numismatic nature.

vi. Jewelers' Block Policies.

vii. Fine Arts Dealers.
Such policies may include coverage of money in locked safes or vaults on the Assured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds interest in improvements of buildings.

t. Wool Growers Floaters.

u. Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.

v. Difference in Conditions Coverage excluding fire and extended coverage perils.

w. Electronic Data Processing Policies.

C. Unless otherwise permitted, nothing in the foregoing shall be construed to permit MARINE OR TRANSPORTATION POLICIES TO COVER:

1. Storage of assured's merchandise, except as hereinbefore provided.
2. Merchandise in course of manufacture, the property of and on the premises of the manufacturer.
3. Furniture and fixtures and improvements and betterments to buildings.
4. Monies and/or securities in safes, vaults, safety deposit vaults, bank or assured's premises, except while in course of transportation.

Historical Note

Former General Rule 59-4; Amended effective August 30, 1985 (Supp. 85-4). R20-6-602 recodified from R4-14-602 (Supp. 95-1).

R20-6-603. Repealed

Historical Note

Former General Rule 69-18; Repealed effective July 27, 1981 (Supp. 81-4). R20-6-603 recodified from R4-14-603 (Supp. 95-1).

R20-6-604. Definitions

The definitions in A.R.S. § 20-1603 and this Section apply to R20-6-604 through R20-6-604.10.

"Actual loss ratio" means incurred claims divided by earned premiums at rates in use.

"Actuarially equivalent" means of equal actuarial present value determined as of a given date with each value based on the same set of actuarial assumptions. When used in this Article in reference to rates and coverage, "actuarially equivalent" means a rate or coverage that is actuarially determined to yield

loss ratios of 50% for credit life insurance and 60% for credit disability insurance.

"Credit insurance" means credit life insurance, credit disability insurance, or both, but does not include any insurance for which there is no identifiable charge.

"Earned premiums" means earned premiums at prima facie rates and earned premiums at rates in use.

"Earned premiums at prima facie rates" means an insurer's actual earned premiums, adjusted to the amount that the insurer would have earned if the insurer's premium rates had equaled the prima facie rates in effect during the experience period.

"Earned premiums at rates in use" means the premiums that an insurer actually earns on the premium rates the insurer charges during an experience period.

"Evidence of individual insurability" means information about a debtor's health status or medical history that a debtor provides as a condition of credit insurance becoming effective.

"Experience" means an insurer's earned premiums and incurred claims during an experience period.

"Experience period" means a period of time for which an insurer reports income and expense information on the insurer's credit insurance business.

"Final adjusted rates" means the prima facie rates referred to in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08.

"Gross debt" means the sum of the remaining payments that a debtor owes a creditor.

"Identifiable charge" means a charge for credit insurance that is imposed on a debtor with credit insurance but not on a debtor without credit insurance, and includes a charge for insurance that is disclosed in the credit or other financial instrument furnished to the debtor, which sets forth the financial elements of a credit transaction, and any difference in finance, interest, service charges, or other similar charges made to a debtor in like circumstances except for the debtor's status as insured or noninsured.

"Incurred claims" means the total claims an insurer pays during an experience period, adjusted for the change in the claim reserves.

"Net debt" means the amount necessary to liquidate a debt in a single lump-sum payment excluding unearned interest and other unearned finance charges.

"Plan of credit insurance" means an insurance plan based on one of the following rate and coverage categories:

Credit life insurance, other than on revolving accounts, including joint and single life coverage, decreasing and level insurance, and outstanding balance and single premium;

Credit life insurance on revolving accounts;

Credit life insurance on an age-graded basis;

Credit disability insurance, other than on revolving accounts, including outstanding balance and single premium, and each combination of waiting period and retroactive or non-retroactive benefits;

Credit disability insurance on revolving accounts, including each combination of waiting period and retroactive or non-retroactive benefits.

"Preexisting condition" means a condition:

For which a debtor received medical advice, consultation, or treatment within six months before the effective date of credit insurance coverage; and

From which the debtor dies, in the case of life insurance, or becomes disabled, in the case of disability insurance, within six months after the effective date of coverage.

"Prima facie adjusted loss ratio" means incurred claims divided by earned premiums at prima facie rates.

"Prima facie rates" means the rates established by the Director as prescribed in R20-6-604.03.

"Reasonableness standard" means the requirement in A.R.S. § 20-1610(B) that an insurer's premiums for credit insurance shall not be excessive in relation to the benefits provided under the policy.

"Rule of Anticipation" means the product of the gross single premium per $100 of indebtedness for a debtor's remaining term of indebtedness, times the number of hundreds of dollars of remaining indebtedness.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

Exhibit A. Repealed

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.01. Rights and Treatment of Debtors

A. Creditor Obligations.

1. Multiple plans of insurance. If a creditor makes more than one plan of credit insurance available to debtors, the creditor shall inform each debtor of each plan for which the debtor is eligible and of the premium and charges for each plan.
2. Substitution. If a creditor requires a debtor to have credit insurance as additional security for a debt, the creditor shall inform the debtor in writing of the debtor's right to obtain alternative coverage as prescribed in A.R.S. § 20-1614 before the loan transaction is completed.
3. Remittance of premiums. If a creditor adds an insurance charge or premium to a debt, the creditor shall remit the insurance charge or premium to the insurer within 60 days after it is added to the debt.

B. Creditor and insurer obligations regarding insurance on refinanced debt.
1. If a debt is discharged because the debtor refinances the debt before the scheduled maturity date, the creditor shall notify the insurer that issued the credit insurance on the discharged debt.
2. An insurer shall not issue any credit insurance that covers the refinanced debt with an effective date preceding the termination date of the insurance on the original debt.
3. The insurer issuing the coverage on the discharged debt shall refund to or credit the debtor with all unearned insurance charges or premium according to R20-6-604.06.
4. If a debt is refinanced, the effective date of the policy provisions in any new insurance covering the refinanced debt shall be the first date on which the debtor became insured under the previous policy. An insurer may apply any new exclusion period or preexisting condition limitation only to the portion of the new loan that exceeds the previous loan.

C. Required policy provisions.
1. Termination provisions for group policies. A group credit insurance policy shall provide for continued coverage of debtors covered under the policy if the policy terminates, as follows:
   a. For a policy with a single premium payment, or any other payment method that prepays coverage for more than one month, a provision requiring continued insurance coverage for the entire period for which the premium has been paid; and
   b. For a policy with a monthly premium payment, a provision requiring the insurer to send the debtor a termination notice at least 30 days before the effective date of termination, unless an insurer is issuing replacement coverage in at least the same amount, without lapse of coverage.
2. Maximum aggregate provisions. A provision in an individual policy or group certificate that sets a maximum limit on total claim payments shall apply only to that individual policy or group certificate.

D. Creditor and insurer obligations when debtor prepays debt.
1. Except as provided in subsection (D)(2), if a debtor prepays a debt in full, any credit insurance covering the debt shall terminate on the date of prepayment. The creditor and insurer shall refund to or credit the debtor with any unearned premium according to R20-6-604.06.
2. If a debt is fully prepaid because of the debtor's death or any other lump-sum credit insurance payment, a creditor or insurer is not required to refund premium for the coverage under which the lump sum was paid.
3. If a claim under credit disability coverage is in progress at the time of prepayment, the insurer:
   a. May calculate the refund as if the prepayment did not occur until the end of the period for payment of benefits, and
   b. Is not required to refund premiums for any period for which credit disability benefits are payable.

E. Benefits payable on revolving account. If a debtor is paying for credit insurance coverage on a revolving account and dies, the insurer shall pay a benefit amount equal to the amount of indebtedness outstanding on the date of death. The insurer may exclude preexisting conditions occurring within six months of any advance on the revolving account, running separately for each advance or charge.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.02. Satisfying the Reasonableness Standard

A. An insurer shall comply with all requirements of A.R.S. § 20-1610 regarding premium and insurance charges.

B. An insurer may satisfy the reasonableness standard in A.R.S. § 20-1610(B) if the insurer's premium rate develops a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.

C. While in effect, the rates described in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08 are conclusively presumed to develop the loss ratios described in subsection (B). For purposes of prospective effect, the Department may rebut this presumption by disapproving or withdrawing approval for the rates as prescribed in A.R.S. § 20-1610.

D. An insurer may provide coverage other than the standard coverage described in R20-6-604.04 and R20-6-604.05. An insurer that wishes to provide nonstandard coverage shall:
1. File the nonstandard coverage policy information as prescribed in A.R.S. § 20-1609, and
2. Demonstrate that the rates for the coverage are reasonably expected to develop a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.03. Determination of Prima Facie Rates

A. The Director shall, by order, establish prima facie rates as prescribed in this Section.

B. At least once every three years, the Director shall:
1. Determine the rate of expected claims on a statewide basis;
2. Compare the rate of expected claims with the rate of actual claims for the past three years determined from the incurred claims and earned premiums at prima facie rates; and
3. If the Director determines that the prima facie rates require adjustment, issue a notice of hearing and proposed order adjusting the actual statewide prima facie rates. The hearing date on the proposed order shall be no earlier than 45 days from the date of the notice.

C. The Director shall mail a copy of the notice and proposed order to:
1. Each insurer that reported transaction of credit insurance on its annual statement immediately preceding the date of the notice, and
2. Any other person who sends the Director a written request for notice of proceedings to adjust the prima facie rates.

D. Any person may submit written comments to the Director or appear at the hearing and provide oral comments on the record. Written comments shall be received no later than the close of record date specified in the notice of hearing.

E. The Director shall:
1. Consider written and oral comments; and
2. Issue a final order setting prima facie rates no later than 30 days after the close of record date specified in the notice of hearing.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.04. Credit Life Insurance Rates and Provisions

A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit life insurance.

B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.

C. A credit life insurance policy shall meet the requirements listed in this Section. The policy shall:

1. Provide coverage for death, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of being eligible;
2. Have no exclusions other than for:
   a. Suicide within six months after the effective date of coverage, or
   b. A preexisting condition;
3. Have no age restrictions, except the following permissible exclusions:
   a. An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 70 and that all insurance shall terminate on a debtor attaining age 70; and
   b. An age restriction for a revolving credit life insurance policy that:
      i. Excludes a class of debtors determined by age, or
      ii. Provides for termination of insurance or reduction in the amount of insurance when a debtor reaches age 70; and
4. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.05. Credit Disability Insurance Rates and Provisions

A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit disability insurance.

B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.

C. A credit disability insurance policy shall meet the requirements listed in this Section. The policy shall:

1. Provide coverage for disability, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of becoming eligible;
2. Include a definition of disability that is no more restrictive than the following:
   a. For the first 12 months of disability, the inability of the insured to perform the essential functions of the insured's occupation; and
   b. After the first 12 months of disability, the inability of the insured to perform the essential functions of any occupation for which the insured is reasonably suited by virtue of education, training, or experience;
3. Not include any employment requirement that a debtor be employed more than full-time on the effective date of coverage, with a definition of "full-time" as a regular work week of at least 30 hours;
4. Have no exclusions other than for disabilities resulting from:
   a. Normal pregnancy,
   b. Intentionally self-inflicted injury, or
   c. A preexisting condition;
5. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge;
6. Have no age restrictions, except the following permissible exclusion:
   An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 65 and that all insurance shall terminate on a debtor attaining age 66; and
7. Include a provision for a daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.06. Refund Methods

A. When refunding premiums as prescribed in A.R.S. § 20-1611, an insurer shall use the following methods:

1. For insurance paid by a single premium, the Rule of Anticipation method; and
2. For insurance paid by other than a single premium, a method that refunds at least the pro rata gross unearned amount charged to the debtor.

B. The Director may approve other refund methods similar to those described in subsection (A), that are actuarially equivalent to the type of coverage the debtor purchased.

C. An insurer's refund method may recognize adjustments to a daily basis for interest or payments if the adjustments are consistent with the underlying credit transaction.

D. An insurer is not required to refund any amount less than $5.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.07. Experience Reports

A. By April 1 of each year, an insurer that transacts credit insurance in this state shall file with the Director an experience report, on a form specified by the Director, for each class of business that the insurer transacts as provided in this Section.

1. In this Section, a "class of business" means:
   a. Credit unions;
   b. Banks, savings and loan institutions, and mortgage companies;
   c. Finance companies, small loan companies, and consumer lenders defined in A.R.S. § 6-601(5);
   d. Dealers, including auto, truck, and boat dealers, retail stores, and other persons selling financed goods; and
   e. All other persons selling credit insurance not specifically listed in subsection (A)(1)(a) through (d).
2. The report shall include the following information:

a. Mode of premium payment,
b. Plan of benefits description,
c. Earned premiums,
d. Incurred claims,
e. Loss ratios, and
f. For credit life insurance, mean insurance in force.

B. For each day a report is late, the Director may assess a penalty as prescribed in A.R.S. § 20-223.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.08. Use of Prima Facie Rates; Rate Deviations

A. Use of rates greater than prima facie rates. An insurer may file for approval and use of any deviated rates that are higher than the prima facie rates referred to in R20-6-604.04 and R20-6-604.05 as prescribed in A.R.S. § 20-1610.
1. The deviated rates shall meet the minimum loss ratio standards and other requirements prescribed by R20-6-604.02.
2. The filing shall specify the accounts to which the rates apply.
3. The rates may be:
   a. Applied uniformly to all accounts of the insurer; or
   b. Applied on an equitable basis approved by the Director to accounts of the insurer for which the insurer's experience has been less favorable than expected.

B. Approval period of deviated rates. An insurer may use a deviated rate for the same period of time as the experience period used to establish the rate, not to exceed a period of three years from the date of approval. An insurer may file for a new deviated rate before the end of the approval period, but not more often than once in any 12 month period.

C. Approval is non-transferable. The Director's approval of a deviated rate is not transferable to another insurer. If an insurer acquires an account for which another insurer obtained a deviated rate, the successor insurer may not charge the deviated rate without obtaining approval for the deviated rate as prescribed in subsection (B).

D. Use of rates lower than filed rates. An insurer may use a rate that is less than its filed rate without notice to the Director.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.09. Supervision of Consumer Credit Insurance Operations

A. At least once every three years, an insurer transacting credit insurance in Arizona shall review the credit insurance operations of each creditor with whom the insurer does business to ensure that each creditor is complying with applicable credit insurance laws. The insurer shall review the following:
1. The creditor does not charge rates in excess of the prima facie rates or any deviated rates for which the insurer obtains approval;
2. The creditor makes benefit payments as prescribed in the policy; and
3. The creditor refunds unearned premiums as prescribed in R20-6-604.06.

B. The insurer shall maintain for the Director's inspection a written record of each review and action the insurer takes to address any creditor noncompliance found by the insurer, for at least three years following the end of the review.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.10. Prohibited Transactions

A. The practices listed in this Section are deemed unfair trade practices under A.R.S. § 20-442. An insurer that commits any of the following practices is subject to penalties as prescribed in A.R.S. § 20-456:
1. Offering or providing a creditor with any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than payment of commissions;
2. Agreeing to deposit with a bank or financial institution, the insurer's money or securities as a substitute for a deposit of money or securities that the financial institution would otherwise require from the creditor as a compensating balance or deposit offset for a loan or other advancement; or
3. Depositing money or securities without interest or at a lesser rate of interest than the creditor, bank, or financial institution is currently paying on other similar deposits.

B. This Section does not prohibit an insurer from maintaining demand deposits or premium deposit accounts that are reasonably necessary for use in the ordinary course of the insurer's business.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-605. Emergency Expired

Historical Note
Former General Rule 72-26. Repealed effective December 4, 1986 (Supp. 86-6). Adopted as an emergency effective January 9, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days; re-adopted as an emergency with changes effective March 26, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days (Supp. 90-1). Re-adopted as an emergency without change effective June 20, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. R20-6-605 recodified from R4-14-605 (Supp. 95-1).

R20-6-606. Repealed

Historical Note
Adopted effective July 1, 1980 (Supp. 80-3). Amended effective June 1, 1981. See also subsection (G) (Supp. 81-1). Amended subsections (D), (E)(3)(a), (F)(2)(b), (3)(a), (4)(e), (G), and (H) effective January 11, 1982 (Supp. 82-1). Amended subsections (G) and (H) as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Amended and readopted as an emergency effective November 18, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Corrected and readopted as an emergency effective February 10, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Amended effective August 4, 1989 (Supp. 89-3). Amended and adopted as an emergency effective September 13, 1989 (Supp. 89-3). Emergency expired (Supp. 89-4). Amended effective November 19, 1990 (Supp. 90-4). Repealed by emergency action effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Repealed again by emergency action effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp.

92-1). Repealed effective May 28, 1992 (Supp. 92-2).
R20-6-606 recodified from R4-14-606 (Supp. 95-1).

R20-6-607. Reasonableness of Benefits in Relation to Premium Charged

A. Applicability. This rule shall apply to individual disability insurance (as defined in A.R.S. § 20-253) policy forms and rates.

B. When rate filing is required. Every individual policy form, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.

C. General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this state and that the benefits are reasonable in relation to the premiums.

D. Previously approved forms. Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

1. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums including the anticipated loss ratio for the form.
2. A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons therefor.
3. A history of the experience under existing rates, including at least the data indicated in subsection (D). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.
4. The date and magnitude of each previous rate change, if any.

E. Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit to the NAIC annual statement convention blank. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except the data for calendar years prior to the most recent five years may be combined.

F. Evaluation experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.
3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
4. The mix of business by risk classification.

G. Anticipated loss ratio standard. With respect to a new form or a currently approved form, except currently approved noncancelable policy forms, under which the average annual premium (as defined below) is expected to be at least $200, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

	Renewal Clause			
Type of Coverage	**OR**	**CR**	**GR**	**NC**
Medical expense	60%	55%	55%	50%
Loss of income and other	60%	55%	50%	45%

For a policy form including riders and endorsements, under which the expected average annual premium per policy is $100 or more but less than $200, subtract 5 percentage points from the numbers in the table above, or if less than $100, subtract 10 percentage points.

The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The above anticipated loss ratio standards do not apply to a class of business which is regulated by specific statutes or regulations mandating loss ratios for such business, e.g., Medicare Supplement and Credit Life and Disability.

Definitions of Renewal Clause

OR – Optionally Renewable: renewal is at the option of the insurance company.

CR – Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR – Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC – Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

H. Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (F) above.

1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;
2. The anticipated loss ratio derived by dividing (a) by (b) where
   a. Is the sum of the accumulated benefits, from the original effective date of the form or the effective

date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits, and

b. Is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums.

Such present values shall be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

I. Anticipated loss ratios lower than those indicated in subsections (H) and (I) will require justification based on the special circumstances that may be applicable.

1. Examples of coverages requiring special consideration are as follows:
   a. Accident only;
   b. Short term nonrenewable, e.g., airline trip, student accident;
   c. Specified peril, e.g., common carrier;
   d. Other special risks.
2. Examples of other factors requiring special consideration are as follows:
   a. Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
   b. Extraordinary expenses;
   c. High risk of claim fluctuation because of the low loss frequency of the catastrophic, or experimental nature of the coverage;
   d. Product features such as long elimination periods, high deductibles and high maximum limits;
   e. The industrial or debit method of distribution;
   f. Forms issued prior to the effective date of this rule.

   Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.
3. Notwithstanding the foregoing paragraphs to the contrary, hospital indemnity and cancer and other dread diseases policies shall develop the loss ratios pursuant to subsection (G).

J. Severability provision. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

K. Effective date. This rule shall become effective upon filing with the Secretary of State and shall apply to all individual disability policy form and rate filings submitted on and after said date.

Historical Note

Adopted effective July 14, 1981 (Supp. 81-1). R20-6-607 recodified from R4-14-607 (Supp. 95-1).

ARTICLE 7. LICENSING PROVISIONS AND PROCEDURES

R20-6-701. Repealed

Historical Note

Former General Rule 56-1; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-701 recodified from R4-14-701 (Supp. 95-1).

R20-6-702. Expired

Historical Note

Former General Rule 56-2. R20-6-702 recodified from R4-14-702 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-703. Expired

Historical Note

Former General Rule 61-6. R20-6-703 recodified from R4-14-703 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-704. Expired

Historical Note

Former General Rule 6-19. R20-6-704 recodified from R4-14-704 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-705. Expired

Historical Note

Former General Rule 66-13. R20-6-705 recodified from R4-14-705 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-706. Expired

Historical Note

Former General Rule 69-15; Repealed effective February 22, 1977 (Supp. 77-1). New Section R4-14-706 adopted effective November 5, 1980 (Supp. 80-5). R20-6-706 recodified from R4-14-706 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-707. Expired

Historical Note

Former General Rule 69-18; Amended effective March 17, 1981 (Supp. 81-2). R20-6-707 recodified from R4-14-707 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-708. Licensing Time-frames

A. Definitions. The definitions listed below apply in this Section.

1. *"Administrative completeness review time frame" means the number of days from the Department's receipt of an application for a license until the Department determines that the application contains all components required by statute or rule, including all information required to be submitted by other government agencies* A.R.S. § 41-1072 (1).
2. "License" has the meaning prescribed in A.R.S. § 41-1001(10).
3. *"Overall time frame" means the number of days after the Department's receipt of an application for a license dur-*

ing which the Department determines whether to grant or deny a license. The overall time frame consists of both the administrative completeness review time frame and the substantive review time frame A.R.S. § 41-1072 (2).

4. *"Substantive review time frame" means the number of days after the completion of the administrative completeness review time frame during which the Department determines whether an application or applicant for a license meets all substantive criteria required by state or rule* A.R.S. § 41-1072(3).

B. The time-frames listed in Table A apply to licenses issued by the Department. The licensing time-frames consist of an administrative completeness review, a substantive review, and an overall review.

C. Within the time-frame for the administrative completeness review set forth in Table A, the Department shall notify the applicant in writing of whether the application is complete or incomplete. If the application is incomplete, the Department shall issue a notice of deficiency to the applicant specifying what information or component is required to make the application administratively complete.

1. If the Department determines that an application for a license is not administratively complete, the Department shall include a comprehensive list of the specific deficiencies in the written notice provided under subsection (C). If the Department issues a written notice of deficiency within the administrative completeness review time-frame, the administrative completeness review time-frame and the overall review time-frame are suspended from the date the notice is issued until the date that the Department receives the missing information from the applicant.
2. If an applicant does not make some response to each specific deficiency in a notice of deficiency issued during an administrative completeness review, the Department may issue a notice to the applicant within 10 days after receipt of the applicant's response, stating that the response is inadequate. The notice of inadequate response shall identify each specified deficiency to which the applicant did not make some response.
   a. If the Department issues a notice of inadequate response under this subsection, the suspension of the administrative completeness review time-frame and the overall time-frame is not terminated.
   b. If the Department does not issue a notice of inadequate response under this subsection, the Department is not precluded from issuing additional notices of deficiency during an administrative completeness review.
3. If an applicant does not make some response to each specified deficiency in a notice of deficiency issued under subsection (C)(2) within 60 days after the date of a notice of deficiency or within 60 days after a notice of inadequate response issued under subsection (C)(2), the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.

D. Within the time-frame for the substantive review set forth in Table A, the Department may issue one comprehensive written request for additional information to the applicant specifying each component or item of information required.

1. If the Department issues a comprehensive written request for additional information within the substantive review time-frame, the substantive review time-frame and the overall time-frame are suspended from the date the written request is issued until the date that the Department receives the additional information from the applicant.
2. If an applicant does not make some response to each component or item of information requested in a comprehensive written request for additional information, the Department may issue a notice to the applicant within 10 days after receipt of the applicant's response stating that the response is inadequate. The notice of inadequate response shall identify each component or item of information required, to which the applicant did make some response.
   a. If the Department issues a notice of inadequate response under this subsection, the suspension of the substantive review time-frame and overall time-frame is not terminated.
   b. If the Department does not issue a notice of inadequate response under this subsection, the Department is not precluded from later issuing supplemental requests by mutual agreement for additional information, during the substantive review.
3. If an applicant does not make some response to each component or item of information required in a comprehensive written request or a supplemental request for additional information, within 60 days after the date of a comprehensive written request or within 60 days after the date of the supplemental request, the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.

E. Within the overall time-frames set forth in Table A, unless extended by mutual agreement under A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or the applicant's right to appeal.

F. In computing the time periods prescribed in these time-frame rules, the last day of a notice period is included in the computation, unless it is a Saturday, Sunday, or legal holiday.

G. This rule applies to applications filed on or after January 1, 1999.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C. (Supp. 76-1). Repealed effective January 8, 1980 (Supp. 80-1). R20-6-708 recodified from R4-14-708 (Supp. 95-1). Amended effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4).

R20-6-709. Repealed

Historical Note

Former General Rule 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-709 recodified from R4-14-709 (Supp. 95-1).

Table A. Licensing Time-frames

License	Relevant A.R.S.	Administrative Completeness	Substantive Review	Overall Time-frame
Certificate of Authority*	§ 20-216	210	90	300
Certificate of Exemption	§ 20-401.05	92	30	122
Reinsurance Intermediary	§ 20-486.01	120	60	180
Hospital, Medical, Dental, and Optometric Service Corporation	§ 20-825	210	90	300
Prepaid Dental Plan Organization	§ 20-1004	210	90	300
Life Care Provider Permit*	§ 20-1803	60	30	90
Health Care Services Organization	§ 20-1052	210	90	300
Mechanical Reimbursement Reinsurer	§ 20-1096.04	210	90	300
Prepaid Legal Insurer*	§ 20-1097.02	45	15	60
Service Representative	§ 20-285	120	60	180
Managing General Agent-Firm	§ 20-284	120	60	180
Managing General Agent-Individual	§ 20-288	120	60	180
Risk Management Consultant	§ 20-289	120	60	180
Agent, Broker and Solicitor	§ 20-291	120	60	180
Nonresident Agent and Broker	§ 20-303	120	60	180
Vending Machine	§ 20-306	120	60	180
Limited Travel Agent	§ 20-306.01	120	60	180
Adjuster	§ 20-312	120	60	180
Bail Bond Agent	§ 20-319	120	60	180
Surplus Lines Broker	§ 20-411	120	60	180
Title Insurance Agent	§ 20-1580	120	60	180
Credit Life and Disability Agents	§ 20-1612	120	60	180
Variable Contract Agent	§ 20-2662	120	60	180
Utilization Review Agent	§ 20-2505	30	90	120
Rating Organization*	§ 20-361	30	30	60
Rate Service Organization	§ 20-389	60	60	120
Qualifying Surplus Lines Insurer	§ 20-413	45	30	75
Third Party Administrator	§ 20-485.12	45	45	90
Service Companies	§ 20-1095.01	30	30	60
Risk Retention Group (Foreign)*	§ 20-2403	60	0	60
Risk Purchasing Groups	§ 20-2407	30	30	60

* Statutory time-frames

Historical Note

Table 1 adopted effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4).

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES

R20-6-801. Unfair Claims Settlement Practices

A. Applicability. This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts except policies of Worker's Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.

B. Definitions

1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.
2. "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.
3. "Director" means the Director of Insurance of the State of Arizona.

4. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by such policy or contract.
5. "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.
6. "Insurer" has the meaning of A.R.S. § 20-106(C).
7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.
8. "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
9. "Person" has the meaning of A.R.S. § 20-105.
10. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.
11. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

C. File and record documentation. The insurer's claim files shall be subject to examination by the Director or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

D. Misrepresentation of policy provisions
1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
2. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis therefor.
4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.
5. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from its total liability.

E. Failure to acknowledge pertinent communications
1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
2. Every insurer, upon receipt of any inquiry from the Department of Insurance respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.
3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
4. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with paragraph (1) of this subsection.

F. Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time.

G. Standards for prompt, fair and equitable settlements applicable to all insurers
1. Notice of acceptance of denial of claim.
   a. Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
   b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.
   c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subparagraphs (a) and (b) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
2. If a claim is denied for reasons other than those described in subparagraph (a) above, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.
4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or

contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. Such notice shall be given to first party claimants 30 days and to third party claimants 60 days before the date on which such time limit may expire.

5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

H. Standards for prompt, fair and equitable settlements applicable to automobile insurance

1. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
   a. The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
   b. The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:
      i. The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.
      ii. One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.
   c. When a first party automobile total loss is settled on a basis which deviates from the methods described in subparagraphs (a) and (b) above, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.
2. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy or insurance contract.
3. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.
4. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.
5. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.
6. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.
7. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
8. The insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which the insurer would pay if the repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

I. Severability. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.

J. Effective date. This rule shall become effective 90 days from the date of filing with the Secretary of State.

Historical Note

Adopted effective January 12, 1982 (Supp. 81-5). R20-6-801 recodified from R4-14-801 (Supp. 95-1).

R20-6-802. Emergency Expired

Historical Note

Emergency rule adopted effective May 31, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule readopted without change effective September 5, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. R20-6-802 recodified from R4-14-802 (Supp. 95-1).

ARTICLE 9. TERMINATION OR DISSOLUTION

R20-6-901. Reserved

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1001. Applicability and Scope

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date hereof by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care services organizations and all similar organizations.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1001 recodified from R4-14-1001 (Supp. 95-1).

R20-6-1002. Definitions

A. For purposes of this Article, the terms "long-term care insurance," "group long-term care insurance," "director," "applicant," "policy" and "certificate" shall have the meanings as set forth in A.R.S. § 20-1691.

B. A "managed-care plan" is a health care or assisted living agreement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1002 recodified from R4-14-1002 (Supp. 95-1).

R20-6-1003. Policy Definitions

A. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.
2. "Guaranteed renewable" means the insured has the right to continue the long-term-care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
3. "Home health services" means those services described A.R.S. § 36-151.
4. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
5. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
6. "Noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.

C. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility" "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1003 recodified from R4-14-1003 (Supp. 95-1).

R20-6-1004. Policy Provisions and Practices: Renewability; Exclusions and Limitations; Extension of Benefits Continuation or Conversion; Discontinuance and Replacement; Home Health Care

A. Renewability provisions.

1. Individual long-term care insurance policies shall contain a renewability provision. No policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable." Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
   This requirement shall apply to those long-term care policies which are part of or combined with life insurance policies which do not contain a renewability provision and under which the right not to renew is reserved solely to the policyholder.
2. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of this Article.

B. Limitations and Exclusions.

1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited by A.R.S. §§ 20-1691.02 and 20-1691.03 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."
3. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
   a. Preexisting conditions or disease;
   b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
   c. Alcoholism and drug addiction;
   d. Illness, treatment or medical condition arising out of:
      i. War, declared or undeclared, or act of war;
      ii. Participation in a felony, riot or insurrection.;
      iii. Service in the armed forces or units auxiliary thereto;
      iv. Suicide, attempted suicide or intentionally self-inflicted injury; or
      v. Aviation, if non-fare-paying passenger.
   e. Treatment provided in a government facility, unless otherwise required by law; services for which benefits are available under Medicare or other governmental program, except Medicaid; any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
   f. Subsection (B) of this rule is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of benefits. Long-term care insurance policies shall provide that termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care

insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

D. Continuation or conversion provisions.

1. Group long-term care insurance issued in this state on or after the effective date of this Section shall provide covered individuals with a basis for continuation or conversion of coverage.
2. A policy providing a basis for continuation of coverage shall include a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
3. A policy providing a basis for conversion of coverage shall include a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been insured under the group policy (and any group policy which it replaced), shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.
   a. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
   b. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.
   c. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
4. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
   a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
   b. The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:
      i. Providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and
      ii. The premium for which is calculated in a manner consistent with the requirements of paragraph (D)(3)(c) of this Section.
5. Notwithstanding any other provision of this Section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
6. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group remained in force and effect.
7. Notwithstanding any other provision of this Section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

E. Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

F. Minimum standards for home health care benefits.

1. A long-term care insurance policy or certificate may not, if it provides benefits for home-health services, limit or exclude benefits:
   a. By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health services were not provided;
   b. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic ser-

vices in a home or community setting before home health services are covered;
c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;
d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.
e. By requiring that the insured/claimant have an acute condition before home health services are covered;
f. By limiting benefits to services provided by Medicare-certified agencies or providers.
2. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Historical Note
Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1004 recodified from R4-14-1004 (Supp. 95-1).

R20-6-1005. Inflation Protection

A. No insurer may offer a insurance policy unless the insurer offers, at the time of purchase, the option to purchase a policy with an inflation protection provision to address the reduction or limitation on the value of benefits that may result from inflation over time. The terms of such provision shall be no less favorable than the following:
1. A term providing for increases in benefit levels compounding annually at a rate of no less than 5%;
2. A term providing for guaranteed periodic increases in benefit levels without requiring evidence of insurability or health status, provided the option for the previous period had not been declined. The increased benefit shall be no less than the difference between the existing benefit and that benefit compounded annually at a rate of no less than 5% from the purchase of the existing benefit until the year in which the offer is made; or
3. A term providing for a specified percentage of actual or reasonable charges that is not limited to a maximum indemnity amount.

B. Where the policy is issued to a group, the required offer in subsection (A) shall be made to the group policyholder; except, if the policy is issued to a group authorized by A.R.S. § 20-1691.02(D) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in subsection (A) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. Insurers shall include the following information in or with the outline of coverage:
1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a hypothetical or a graphic demonstration for the purposes of this disclosure.

Historical Note
Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1005 recodified from R4-14-1005 (Supp. 95-1).

R20-6-1006. Required Disclosure Provisions

A. Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase premium during policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

B. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

C. Disclosure of tax consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

Historical Note
Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1006 recodified from R4-14-1006 (Supp. 95-1).

R20-6-1007. Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by A.R.S. § 20-1691(4)(a)(i), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.
1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
   a. If so, with which company?
   b. If that policy lapsed, when did it lapse?
3. Are you covered by Medicaid?
4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.
1. List policies sold which are still in force.

2. List policies sold in the past five years which are no longer in force.

C. Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be in the form prescribed in Appendix A.

D. Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be in the form prescribed in Appendix B.

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

G. Reporting requirements.

1. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
2. Each insurer shall report annually by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by paragraph (1) of this subsection.
3. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.
4. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
5. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.
6 For purposes of this Section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1007 recodified from R4-14-1007 (Supp. 95-1).

R20-6-1008. Prohibition Against Post-claims Underwriting

A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

B. Except for policies or certificates which are guaranteed issue:

1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: **Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.**
2. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: **Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! if, for any reason, any of your answers are incorrect, contact the company at this address: [insert address].**
3. Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:
   a. A report of a physical examination;
   b. An assessment of functional capacity;
   c. An attending physician's statement; or
   d. Copies of medical records.

C. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

D. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state- and countrywide, except those which the insured voluntarily effectuated.

E. On or before March 31 of each year, insurers shall report the following information to the Director for the prior calendar year:

1. Company name, address, phone number;
2. As to each rescission except those voluntarily effectuated by the insured:
   a. Policy form number;
   b. Policy and certificate number;
   c. Name of the insured;
   d. Date of policy issuance;
   e. Date(s) claim(s) submitted;
   f. Date of rescission; and
   g. Detailed reason for rescission.
3. Signature, name and title of the preparer, and date prepared.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1008 recodified from R4-14-1008 (Supp. 95-1).

R20-6-1009. Discretionary Powers of Director

The Director may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provision of this Article with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
   a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
   b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
   c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1009 recodified from R4-14-1009 (Supp. 95-1).

R20-6-1010. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with A.R.S. § 20-510. Claim reserves shall also be established in the case when such policy or rider is in claim status.

B. Reserves for policies and riders subject to this subsection may be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations may be acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs including, but not limited to, the following:

1. Definition of insured events;
2. Covered long-term care facilities;
3. Existence of home convalescence care coverage;
4. Definition of facilities;
5. Existence or absence of barriers to eligibility;
6. Premium waiver provision;
7. Renewability;
8. Ability to raise premiums;
9. Marketing method;
10. Underwriting procedures;
11. Claims adjustment procedures;
12. Waiting period;
13. Maximum benefit;
14. Availability of eligible facilities;
15. Margins in claim costs;
16. Optional nature of benefit;
17. Delay in eligibility for benefit;
18. Inflation protection provisions; and
19. Guaranteed insurability option.

D. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

E. When long-term care benefits are provided other than as in subsection (A), reserves shall be determined in accordance with A.R.S. § 20-508.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1010 recodified from R4-14-1010 (Supp. 95-1).

R20-6-1011. Loss ratio

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60% calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles and high maximum limits.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1011 recodified from R4-14-1011 (Supp. 95-1).

R20-6-1012. Filing Requirement for Group Policy Issued in Another State

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to A.R.S. § 20-1691.02(D), it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1012 recodified from R4-14-1012 (Supp. 95-1).

R20-6-1013. Standards for Marketing

A. Every insurer, health care service organization or other entity marketing long-term care insurance coverage in this state, directly or through its producers shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate, and to assure excessive insurance is not sold or issued.
2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice of buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of cov-

erage. The buyer is advised to review carefully all policy limitations."

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

B. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection (A).

C. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convent any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly or any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

D. Appropriateness of recommended purchase. In recommending the purchase of replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1013 recodified from R4-14-1013 (Supp. 95-1).

R20-6-1014. Filing Requirements for Advertising

Every insurer, health care service organization or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Director for review and approval by the Director pursuant to A.R.S. § 20-1110(E). In addition, all advertisements shall be retained by the insurer, health care service organization or other entity for at least three years from the date the advertisement was first used.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1014 recodified from R4-14-1014 (Supp. 95-1).

R20-6-1015. Standard Format Outline of Coverage

A. The outline of coverage shall be delivered to applicants as required by A.R.S. § 20-1691.04.

B. The outline of coverage shall be a free-standing document, using no smaller than 10 point type, and shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage prescribed in Appendix C is mandatory, unless otherwise specifically indicated.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1015 recodified from R4-14-1015 (Supp. 95-1).

R20-6-1016. Requirement to Deliver Shopper's Guide

All prospective applicants of a long-term care insurance policy or certificate shall be provided a long-term care shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners.

1. In the case of agent solicitation, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.
2. In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1016 recodified from R4-14-1016 (Supp. 95-1).

APPENDIX A
NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides [thirty (30)] [ten (10)] days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed our current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probation periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your

best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been property recorded.

_____
(Signature of Agency, Broker or Other Representative)

_____
(Company Name)

(Typed Name and Address of Agent or Broker)

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Historical Note
Adopted effective August 10, 1992 (Supp. 92-3).

APPENDIX B
NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herein issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly, Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

APPENDIX C

[COMPANY NAME]
[ADDRESS - CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] (certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!
3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]
(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
   (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
   (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.
   This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]
6. BENEFITS PROVIDED BY THIS POLICY
   (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
   (b) [Institutional benefits, by skill level.]
   (c) [Non-institutional benefits, by skill level.]
   [Any benefit screens must be explained in this Section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]
7. LIMITATIONS AND EXCLUSIONS.
   [Describe:
   (a) Preexisting conditions;
   (b) Non-eligible facilities/provider;
   (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
   (d) Exclusions/exceptions;
   (e) Limitations.]
   [This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]
   THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.
8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:
   (a) That the benefit level will not increase over time;
   (b) Any automatic benefit adjustment provisions;
   (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
   (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
   (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.
   [(a) Describe the policy renewability provisions;
   (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
   (c) Describe waiver of premium provisions or state that there are not such provisions;
   (d) State whether or not the company has a right to change premium and, if such a right exists, describe clearly and concisely each circumstance under which premium may change.]
10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
    [State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]
11. PREMIUM.
    [(a) State the total annual premium for the policy;
    (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
12. ADDITIONAL FEATURES.
    [(a) Indicate if medical underwriting is used;
    (b Describe other important features.]

Historical Note
Adopted effective August 10, 1992 (Supp. 92-3).

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Applicability and Scope

A. Except as otherwise specifically provided in R20-6-1104, R20-6-1109, R20-6-1110, R20-6-1113 and R20-6-1118, this Article applies to:
1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Article; and
2. All certificates issued under group Medicare supplement policies and delivered or issued for delivery in this state.

B. This Article does not apply to a policy or contract of:
1. One or more employers or labor organizations; or
2. The trustees of a fund established by one or more employers or labor organizations or combination of employers and labor organizations, for their employees, former employees, or a combination of employees and former employees, or for members, former members, or a combination of members and former members of the labor organizations.

Historical Note
Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1101 recodified from R4-14-

1101 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1102. Definitions

In this Article, the definitions in A.R.S. §§ 20-102 through 20-105 and the following definitions apply.

1. "Activities of daily living" means, but is not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
2. "Applicant" means:
   a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
   b. In the case of a group Medicare supplement policy, the proposed certificate holder.
3. "At-home recovery visit" means the period of time required to provide at-home recovery care, without limit on the duration of time, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.
4. "Bankruptcy" means that a Medicare+Choice organization which is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Arizona.
5. "[ ]" means the amount or text within the brackets is subject to change or variation.
6. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
7. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
8. "Certificate form" means the form on which a certificate is delivered or issued for delivery by an issuer.
9. "Compensation" means pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders' fees.
10. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
11. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.
12. "Creditable coverage" means the type of insurance coverage described in R20-6-1102.01.
13. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act).
14. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services of a Medicare Select issuer or its network providers.
15. "Home" means any place used by an insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.
16. "Insolvency" means that an issuer, licensed to transact the business of insurance in Arizona, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.
17. "Issuer" means insurance companies, fraternal benefit societies, health care services organizations, hospital and medical service associations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
18. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
19. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. § 1395w-28(b)(1), and includes:
   a. Coordinated care plans that provide health care services, including, but not limited to, health care services organization plans (with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;
   b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
   c. Medicare+Choice private fee-for-service plans.
20. "Medicare Handbook" means the publication distributed by the United States Department of Health and Human Services, Health Care Financing Administration, describing Medicare benefits available and premium, deductible, and coinsurance amounts payable.
21. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
22. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
23. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber or member contract of hospital and medical service associations or health care services organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. §§ 1395 et seq.) or a policy issued under a demonstration project specified in 42 U.S.C. § 1395ss Subsection (g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.
24. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with an issuer to provide benefits insured under a Medicare Select policy.
25. "Policy form" means a form on which a policy is delivered or issued for delivery by an issuer.
26. "Restricted network provisions" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.
27. "Secretary" means the Secretary of the United States Department of Health and Human Services.
28. "Service area" means the geographic area within which an issuer is authorized to offer a Medicare Select policy.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1102 recodified from R4-14-1102 (Supp. 95-1). Amended effective

August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1102.01 Creditable Coverage

A. Creditable coverage means, with respect to an individual, coverage provided under:
1. A group health plan;
2. Any health insurance plan;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. § 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health care plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)].

B. Creditable coverage does not include:
1. Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for onsite medical clinics; or
8. Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

C. Creditable coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan:
1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these; and
3. Other similar, limited benefits as are specified in federal regulations.

D. Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits:
1. Coverage only for a specified disease or illness insurance, and
2. Hospital indemnity or other fixed indemnity insurance.

E. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance:
1. Medicare supplemental health insurance as defined in 42 U.S.C. § 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided in chapter 55 of Title 10, United States Code (CHAMPUS); and
3. Similar supplemental coverage provided to supplement coverage under a group health plan.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1).

R20-6-1103. Policy Definitions and Terms; Policy Provisions

A. A person shall not advertise, solicit, or issue for delivery in this state a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this subsection:
1. "Accident," "accidental injury," "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external," "violent," "visible wounds" or similar words of description or characterization.
   a. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of diseases or bodily infirmity or any other cause, and occurs while the insurance coverage is in force."
   b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or any motor vehicle no-fault plan, unless prohibited by law.
2. "Benefit period" or "Medicare benefit period" shall be defined as starting the first day the insured enters the hospital and ends when the insured has been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, including the day of discharge.
3. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined to exclude a facility which is eligible for reimbursement as a convalescent nursing home, extended care facility or skilled nursing facility under Medicare.
4. "Health care expenses" means expenses of health care services organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:
   a. Home office and overhead costs,
   b. Advertising costs,
   c. Commissions and other acquisition costs,
   d. Taxes,
   e. Capital costs,
   f. Administrative costs, and
   g. Claims processing costs.
5. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals but shall not be defined to exclude any entity which is eligible for reimbursement as a "hospital" under Medicare.
6. "Medicare" shall be defined in the policy and certificate. Medicare shall be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act as then constituted and any later amendments or substitutes thereof," or words of similar import.

7. "Medicare eligible expenses" shall be defined as expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.
8. "Physician" shall not be defined to exclude a provider which is eligible for reimbursement as a "physician" under Medicare.
9. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

B. Except for permitted preexisting condition clauses as described in R20-6-1104(B)(1) and R20-6-1105(B)(1) of this Article, a person shall not advertise, solicit, or issue for delivery in this state a Medicare supplement policy or certificate with limitations or exclusions on coverage that are more restrictive than those of Medicare.

C. An issuer of a Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

D. An issuer of a Medicare supplement policy or certificate in force in this state shall ensure that it does not contain benefits that duplicate benefits provided by Medicare.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1103 recodified from R4-14-1103 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before April 1, 1992

A. A person shall not advertise, solicit, or issue a policy or certificate for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the minimum standards listed in this Section. These minimum standards do not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.

B. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months after the effective date of coverage because the losses arise from a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.
4. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:
   a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
   b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
5. An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation without prior written authorization from the director. The director may authorize cancellation or nonrenewal for reasons other than nonpayment of premium or material misrepresentation if the director finds that the renewal or continuation of the Medicare supplement policy or certificate would be hazardous or prejudicial to the issuer's certificate holders or policyholders.
6. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (B)(8), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:
   a. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
   b. An individual Medicare supplement policy that provides only the benefits required to meet the minimum standards described in R20-6-1105(C).
7. If membership in a group is terminated, the issuer shall:
   a. Offer the certificate holder the conversion opportunities described in subsection (B)(6), or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

C. Minimum benefit standards.

1. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
3. Coverage of Part A Medicare-eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
5. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells unless replaced or already paid for under Part B;
6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100]; and
7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced or already paid for under Part A, subject to the Medicare deductible amount.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1104 recodified from R4-14-1104 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after April 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses arise from a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness different from losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.
4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5. Each Medicare supplement policy shall be guaranteed renewable and the issuer:
   a. Shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
   b. Shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
6. If a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subsection (B)(8), the issuer shall offer a certificate holder an individual Medicare supplement policy which, at the option of the certificate holder,
   a. Provides for continuation of the benefits contained in the group policy, or
   b. Provides for benefits that otherwise meet the requirements of subsection (B).
7. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
   a. Offer the certificate holder the conversion opportunity described in subsection (B)(6); or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the replaced group policy on its date of termination. Coverage under the replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.
10. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the medical assistance.
    a. If benefits and premiums are suspended under subsection (B)(10), and if the policyholder or certificate holder loses entitlement to medical assistance under Title XIX of the Social Security Act, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of the entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss of the entitlement and pays the premium attributable to the period beginning when the entitlement to the medical assistance ended.
    b. A Medicare supplement policy shall provide that benefits and premiums under the policy are suspended for any period that may be provided by fed-

eral regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If the policy is suspended and if the policyholder or certificate-holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

c. Reinstitution of coverage under subsection (B)(10)(a) or (B)(10)(b):
   i. Shall not provide for any waiting period with respect to treatment of preexisting conditions,
   ii. Shall provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension, and
   iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

C. Standards for basic "core" benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not instead of the basic "core" package. The "core" package consists of:

1. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced; and
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. Standards for additional benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106:

1. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
2. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
3. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
4. Eighty percent of the Medicare Part B excess charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
5. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
6. Basic outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
7. Extended outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
8. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset;
9. Preventive medical care benefit: Coverage for the following preventive health services:
   a. An annual clinical preventive medical history and physical examination that may include tests and services described in subsection (D)(9)(b) and patient education to address preventive health care measures;
   b. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
      i. Digital rectal examination;
      ii. Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
      iii. Pure tone, air only, hearing screening test, administered or ordered by a physician;
      iv. Serum cholesterol screening every five years;
      v. Thyroid function test; and
      vi. Diabetes screening;
   c. Tetanus and diphtheria booster every 10 years;
   d. Any other tests or preventive measures determined appropriate by the attending physician; and
   e. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This

benefit shall not include payment for any procedure covered by Medicare;

10. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery,
    a. Coverage requirements:
        i. At-home recovery services provided must be primarily services that assist in activities of daily living; and
        ii. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment is approved by Medicare;
    b. Coverage is limited to:
        i. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment,
        ii. The actual charges for each visit to a maximum reimbursement of $40 per visit,
        iii. Sixteen thousand dollars per calendar year,
        iv. Seven visits in any one week,
        v. Care furnished on a visiting basis in the insured's home,
        vi. Services provided by a care provider as defined in R20-6-1102 (4),
        vii. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded, and
        viii. At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.
    c. Coverage is excluded for:
        i. Home care visits paid for by Medicare or other government programs; and
        ii. Care provided by family members, unpaid volunteers, or providers who are not care providers; and
11. New benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits that do not violate any provision of A.R.S. Title 20, or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply with the applicable standards. The new benefits may include benefits that are appropriate to Medicare supplement insurance, new, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1105 recodified from R4-14-1105 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1106. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as described in R20-6-1105(C).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in R20-6-1105(D)(11) and in R20-6-1107.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this rule and conform to the definitions in R20-6-1103. Each benefit shall be structured in accordance with the format and sequence provided in R20-6-1105(C) and (D). For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use other designations, in addition to the benefit plan designations required in subsection (C) of this rule.

E. Format of benefit plans:
1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic "core" benefits common to all benefit plans, as described in R20-6-1105(C).
2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible as described in R20-6-1105(D)(1).
3. Standardized Medicare supplement benefit plan "C" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country described in R20-6-1105(D)(1) through (D)(3), and (D)(8).
4. Standardized Medicare supplement benefit plan "D" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and at-home recovery benefits described in R20-6-1105(D)(1), (D)(2), (D)(8), and (D)(10).
5. Standardized Medicare supplement benefit plan "E" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care defined in R20-6-1105(D)(1), (D)(2), (D)(8), and (D)(9).
6. Standardized Medicare supplement benefit plan "F" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(8).
7. Standardized Medicare supplement benefit high deductible plan "F" shall include only 100% of covered expenses following the payment of the annual high deductible plan "F" deductible.
    a. The covered expenses include:
        i. The core benefit as defined in R20-6-1105(C),
        ii. The Medicare Part A deductible,
        iii. Skilled nursing facility care,
        iv. The Medicare Part B deductible,

v. One hundred percent of the Medicare Part B excess charges, and
vi. Medically necessary emergency care in a foreign country as defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(8).

b. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles.
c. The annual high deductible Plan "F" deductible is $1500 for 1998 and 1999, and is based on a calendar year. The Secretary shall annually adjust the deductible to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

8. Standardized Medicare supplement benefit plan "G" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and at-home recovery benefit described in R20-6-1105(D)(1), (D)(2), (D)(4), (D)(8), and (D)(10).
9. Standardized Medicare supplement benefit plan "H" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country described in R20-6-1105(D)(1), (D)(2), (D)(6), and (D)(8).
10. Standardized Medicare supplement benefit plan "I" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefits defined in R20-6-1105(D)(1), (D)(2), (D)(5), (D)(6), (D)(8), and (D)(10).
11. Standardized Medicare supplement benefit plan "J" shall include only the core benefit described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended basic prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit described in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(7) through (D)(10).
12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only 100% of covered expenses following the payment of the annual high deductible plan "J" deductible.
    a. The covered expenses include:
        i. The core benefit defined in R6-20-1105(C),
        ii. The Medicare Part A deductible,
        iii. Skilled nursing facility care,
        iv. Medicare Part B deductible,
        v. One hundred percent of the Medicare Part B excess charges,
        vi. Extended outpatient prescription drug benefit,
        vii. Medically necessary emergency care in a foreign county,
        viii. Preventive medical care benefit, and
        ix. At-home recovery benefit defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(7) through (D)(10).
    b. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles.
    c. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1106 recodified from R4-14-1106 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1).

R20-6-1107. Medicare Select Policies and Certificates

A. This rule shall apply to Medicare Select policies and certificates as defined in R20-6-1102.
B. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.
C. The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and 42 U.S.C. 1395ss(t)(1), effective November 5, 1990, and no further amendments, incorporated herein and on file with the Office of the Secretary of State and available from the U.S. Government Printing Office, Washington, D.C., if the Director finds that the issuer has satisfied all of the requirements of this rule.
D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.
E. A Medicare Select issuer shall file a proposed plan of operation with the Director which contains at least the following information:
1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:
    a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
    b. The issuer has considered the demographics of the service area in determining the number of network providers in the service area. The issuer shall further demonstrate that, with respect to current and expected policyholders, the providers in the service area will be able to either:
        i. Deliver adequately all services that are subject to a restricted network provision; or
        ii. Make appropriate referrals.
    c. There are written agreements with network providers describing specific responsibilities.
    d. Emergency care is available 24 hours per day and seven days per week.

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.
3. A description of the grievance procedure to be utilized.
4. A description of the quality assurance program, including:
   a. The formal organizational structure;
   b. The written criteria for selection, retention and removal of network providers; and
   c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
5. A list and description, by specialty, of the network providers.
6. Copies of the written information proposed to be used by the issuer to comply with subsection (I) of this rule.
7. Any other information requested by the Director.

F. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing such changes. Such changes shall be considered approved by the Director after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the Director at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
2. It is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
   a. Other Medicare supplement policies or certificates offered by the issuer; and
   b. Other Medicare Select policies or certificates.
2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.
3. A description of the network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.
4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
5. A description of limitations on referrals to restricted network providers and to other providers.
6. A description of the policyholder's rights of purchase of any other Medicare supplement policy or certificate otherwise offered by the issuer.
7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (I) of this rule and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.
2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
3. Grievances shall be acknowledged within 15 days of receipt and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
4. If a grievance is found to be valid, corrective action shall be taken promptly.
5. All concerned parties shall be notified about the results of a grievance.
6. The issuer shall report no later than each March 31st to the Director regarding its grievance procedure. The report shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare Select policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six months.

For the purposes of this subsection, Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

N. Medicare Select policies or certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this rule should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain

a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purpose of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1107 recodified from R4-14-1107 (Supp. 95-1).

R20-6-1108. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant who submits an application for a policy or certificate before or during the six month period beginning with the first day of the first month in which an individual is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each issuer shall make available each Medicare supplement policy and certificate currently offered by the issuer to all applicants who qualify under this subsection, without regard to age.

B. An issuer shall not exclude benefits based on a preexisting condition if an applicant:

1. Qualifies under subsection (A),
2. Submits an application during the time period in subsection (A), and
3. As of the date of application, has had a continuous period of creditable coverage of at least six months.

C. If an applicant meets the criteria listed in subsections (B)(1) and (B)(2), but has had a continuous period of creditable coverage that is less than six months, an issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

D. Except as provided in subsections (B) and (C) and R20-6-1119, subsection (A) shall not be construed as preventing the exclusion of benefits under a policy or certificate, during the first six months of coverage, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1108 recodified from R4-14-1108 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1).

R20-6-1109. Standards for Claims Payment

A. An issuer shall:

1. Accept a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
2. Notify the participating physician or supplier and the beneficiary of the payment determination;
3. Pay the participating physician or supplier directly;
4. Furnish, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;
5. Pay user fees for claim notices that are transmitted electronically or otherwise; and
6. Provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in subsection (A) above shall be certified on the Medicare supplement insurance experience reporting form.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1109 recodified from R4-14-1109 (Supp. 95-1).

R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium

A. Loss ratio standards.

1. A Medicare supplement policy or certificate form shall not be delivered or issued for delivery unless the policy or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy or certificate:
   a. At least 75% of the aggregate amount of premiums earned in the case of group policies; or
   b. At least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses if coverage is provided by a health care services organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.
2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
3. For policies issued before December 18, 1991, expected claims in relation to premiums shall meet:

a. The originally filed anticipated loss ratio when combined with the actual experience since inception;
b. The appropriate loss ratio requirement from subsection (A)(1) when combined with the actual experience beginning on April 28, 1996, to date; and
c. The appropriate loss ratio requirement from subsection (A)(1) over the entire future period for which the rates are computed to provide coverage.

B. Refund or credit calculation.
1. An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
2. If on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception, a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies or certificates issued within the reporting year shall be excluded.
3. For policies or certificates issued before December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The issuer shall submit the first report under this subsection by May 31, 1998.
4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds .5% of the annualized premium in force as of December 31 of the reporting year. The refund or credit shall include interest from the end of the calendar year to the date of the refund or credit at a rate not less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates.
1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually by no later than January 1 its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, by policy duration for approval by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.
2. Before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:
   a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents necessary to justify the adjustment shall accompany the filing.
      i. An issuer shall make premium adjustments to produce an expected loss ratio under a policy or certificate that conforms with minimum loss ratio standards for Medicare supplement policies or certificates and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described in this subsection shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.
      ii. If an issuer fails to make premium adjustments in accordance with this Section, the Director may order premium adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this Section.
   b. Any riders, endorsements, or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public hearings. The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Section if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.

E. As used in this Section, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1110 recodified from R4-14-1110 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-1111. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Director pursuant to A.R.S. § 20-1110.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director pursuant to R20-6-1110.

C. Except as provided in subsection (C)(1), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.
1. An issuer may offer, with the approval of the Director, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:
   a. The inclusion of new or innovative benefits;
   b. The addition of either direct response or agent marketing methods;

c. The addition of either guaranteed issue or underwritten coverage;
d. The offering of coverage to individuals eligible for Medicare by reason of disability.

2. For the purposes of this rule, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D. Except as provided in paragraph (1) of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Article that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Director in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director, the issuer shall no longer offer for sale the policy form or certificate form in this state.
2. An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (1) of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period of time is in the best interests of the proposed applicants under the new policy form or certificate form.
3. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.
4. A change in the rating structure or methodology shall be considered a discontinuance under this Section unless the issuer complies with the following requirements:
   a. The issuer provides an actuarial memorandum describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.
   b. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest.

E. Except as provided in this subsection, the issuer shall combine the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan for purposes of the refund or credit calculation prescribed in R20-6-1110. Forms assumed under an assumption re-insurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculations.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1111 recodified from R4-14-1111 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

R20-6-1112. Permitted Compensation Requirements

A. An issuer or other entity may provide commission or other compensation to an agent of other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent renewal years must be the same as the provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1112 recodified from R4-14-1112 (Supp. 95-1).

R20-6-1113. Required Disclosure Provisions

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the renewal or continuation provision shall be consistent with the type of contract issued. The provision shall be captioned as a renewal or continuation provision, shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's or certificate holder's age.
2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits or coverage are required by the minimum standards for Medicare supplement policies, or the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits or coverage provided in connection with riders or endorsements, the additional premium charge shall be set forth in the policy.
3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
6. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense-incurred or indemnity basis, to a person eligible for Medicare shall provide to the applicant a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request or, if not requested, no later than at the time the policy is delivered.
7. For the purposes of subsection (A)(6), "form" means language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.
1. As soon as practicable, but no later than 30 days before the annual effective date of any Medicare benefit change, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The notice shall:
   a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
   b. Inform each policyholder and certificate holder when any premium adjustment is to be made due to changes in Medicare.
2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.
3. The notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare supplement policies.
1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, issuers shall obtain an acknowledgment of receipt of the outline from the applicant.
2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."
3. The outline of coverage consists of four parts:
   a. A cover page,
   b. Premium information,
   c. A disclosure page, and
   d. Charts displaying the features of each benefit plan offered by the issuer.
4. The outline of coverage shall be:
   a. In the language and format prescribed in Appendix B, and
   b. In at least 12-point type.
5. The cover page shall:
   a. Show all plans A-J, and
   b. Prominently identify all plans the issuer offers.
6. The cover page or the page immediately following the cover page shall prominently display all possible premiums and modes of payment.
7. The outline of coverage shall include the items in the order prescribed in Appendix B. The information contained in the outline of coverage shall be correct as of the date of its issuance and shall include amounts payable by Medicare, the insured's deductible and what the policy or certificate pays.

D. Notice regarding policies or certificates that are not Medicare supplement policies.
1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in R20-6-1101(B), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in not less than 12-point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.
2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (D)(1) shall provide the applicable statement in Appendix F. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1113 recodified from R4-14-1113 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1).

R20-6-1114. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the questions set forth in Appendix C, designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or

whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements set forth in Appendix C may be used.

B. Agents shall list in the application any other health insurance policies they have sold to the applicant.
1. List policies sold that are still in force.
2. List policies sold in the past five years that are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.

E. The notice required by subsection (D) shall be provided in substantially the form prescribed in Appendix D in no less than 12-point type.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1114 recodified from R4-14-1114 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3).

R20-6-1115. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review and approval by the Director pursuant to A.R.S. § 20-1110(E).

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1115 recodified from R4-14-1115 (Supp. 95-1).

R20-6-1116. Standards for Marketing

A. An issuer, directly or through its producers, shall:
1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
2. Establish marketing procedures to assure excessive insurance is not sold or issued.
3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:
   "Notice to buyer: This policy may not cover all of your medical expenses."
4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
5. Establish auditable procedures for verifying compliance with subsection (A) of this rule.

B. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:
1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this Article.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1116 recodified from R4-14-1116 (Supp. 95-1).

R20-6-1117. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1117 recodified from R4-14-1117 (Supp. 95-1).

R20-6-1118. Report of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate in the form contained in Appendix E:
1. Policy and certificate number, and
2. Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Historical Note

Emergency rule adopted effective December 18, 1991,

pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1118 recodified from R4-14-1118 (Supp. 95-1).

R20-6-1119. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1119 recodified from R4-14-1119 (Supp. 95-1).

R20-6-1120. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Article and the application of such provision to other persons or circumstances shall not be affected thereby.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1120 recodified from R4-14-1120 (Supp. 95-1).

R20-6-1121. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue

1. An eligible person is an individual described in subsection (B) who:
   a. Seeks to enroll under a Medicare supplement policy during the period specified in subsection (C), and
   b. Submits evidence of the date of termination or disenrollment with the application for the policy.
2. With respect to an eligible person, an issuer shall not:
   a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (E) that is offered and is available for issuance to new enrollees by the issuer;
   b. Discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; or
   c. Impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

B. Eligible Person. An eligible person is an individual described in any of the subsections (B)(1) through (B)(7):

1. The individual is enrolled under an employee welfare benefit plan that:
   a. Provides health benefits that supplement the benefits under Medicare, and
   b. Terminates or ceases to provide all supplemental health benefits to the individual;
2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply:
   a. The organization's or plan's certification is terminated;
   b. The organization terminates or otherwise discontinues providing the plan in the area where the individual resides;
   c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   d. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i. The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including a failure to timely provide the individual with medically necessary care for which benefits are available under the plan, or a failure to provide covered care in accordance with applicable quality standards;
      ii. The organization, agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
      iii. The individual meets other exceptional conditions as the Secretary may provide;
3. The individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and any of the conditions listed in subsection (B)(2) apply;
4. The individual is enrolled with an organization listed in this subsection and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (B)(2) or (B)(3):
   a. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost);
   b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   c. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   d. An organization under a Medicare Select policy; and
5. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization;
   b. Of other involuntary termination of coverage or enrollment under the policy;
   c. The issuer of the policy substantially violated a material provision of the policy; or

d. The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

6. The individual meets both of the following conditions:
   a. The individual was enrolled under a Medicare supplement policy, terminates that enrollment, and subsequently enrolls for the first time, with:
      i. Any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare,
      ii. Any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost),
      iii. Any similar organization operating under demonstration project authority;
      iv. Any PACE provider under Section 1894 of the Social Security Act, or
      v. A Medicare Select policy; and
   b. The individual terminates the subsequent enrollment under subsection (B)(6) during any period within the first 12 months of the subsequent enrollment (which the enrollee is allowed to do under Section 1851(e) of the Social Security Act); or
7. The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

C. Guaranteed Issue Time Periods
1. In the case of an eligible person described in subsection (B)(1), the guaranteed issue period:
   a. Begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and
   b. Ends 63 days after the date of the applicable notice;
2. In the case of an individual described in subsections (B)(2), (B)(3), (B)(4), (B)(6) or (B)(7) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;
3. In the case of an individual described in subsection (B)(5)(a):
   a. The guaranteed issue period begins on the earlier of:
      i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice, if any, or
      ii. The date that the applicable coverage is terminated.
   b. The guaranteed issue period ends on the date that is 63 days after the date that coverage terminates;
4. In the case of an individual described in subsections (B)(2), (B)(5)(b), (B)(5)(c), (B)(6) or (B)(7) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 6o days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; and
5. In the case of an individual described in subsection (B) but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after that effective date.

D. Extended Medigap Access for Interrupted Trial Periods
1. In the case of an individual described in subsection (B)(6) (or deemed to be so described under this subsection) whose enrollment with an organization or provider described in subsection (B)(6)(a) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider described in subsection (B)(6)(a), the subsequent enrollment is deemed to be an initial enrollment described in subsection (B)(6).
2. In the case of an individual described in subsection (B)(7) (or deemed to be so described under this subsection) whose enrollment with a plan or in a program described in subsection (B)(7) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program described in subsection (B)(7), the subsequent enrollment is deemed to be an initial enrollment under subsection (B)(7); and
3. For purposes of subsections (B)(6) and (B)(7), an individual's enrollment with an organization or provider described in subsection (B)(6)(a), or with a plan or in a program described in subsection (B)(7) is not considered an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

E. Products to Which Eligible Persons Are Entitled. An eligible person is entitled to the following Medicare supplement policy:
1. Under subsections (B)(1) through (B)(5): a Medicare supplement policy that has a benefit package classified as Plan A, B, C, or F offered by an insurer;
2. Under subsection (B)(6): the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not available, a policy described in subsection (E)(1); and
3. Under subsection (B)(7): any Medicare supplement policy offered by any insurer.

F. Notification provisions
1. At the time of an event described in subsection (B) that causes an individual to lose coverage or benefits due to the termination of a contract, agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated with the notification of termination.
2. At the time of an event described in subsection (B) that causes an individual to cease enrollment under a contract, agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (W) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

	(a) Earned Premium (x)	(b) Incurred Claims (y)
1. Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues (z)		
c. Net (for reporting purposes = line 1a - line 1b)	_____	_____
2. Past Years' Experience (All Policy Years)	_____	_____
3. Total Experience (Net Current Year Plus Past Years' Experience)	_____	_____

4. Refunds Lest Year (Excluding Interest) _____

5. Previous Since Inception (Excluding Interest) _____

6. Refunds Since Inception (Excluding Interest) _____

7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____

8. Experienced Ratio Since Inception _____

   Total Actual Incurred Claims (line 3, col b) = Ratio 2

   Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6)

9. Life Years Exposed Since Inception_____

   If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table)_____

APPENDIX A (CONT'D)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM (continued)
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (W) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

11. Adjustment to Incurred Claims for Credibility

    Ratio 3 = Ratio 2 + Tolerance_____

    If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

    If Ratio 3 is less than the benchmark ratio, then proceed.

12. Adjusted Incurred Claims =_____

    [Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)]
    x Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col a) -
    Refunds Since Inception (line 6) -

    (Adjusted Incurred Claims (line 12))
    (----------)
    (Benchmark Ratio (Ratio 1))

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0. 0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

APPENDIX A (CONT'D)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM (continued)
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (W) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

W = "SMSBP" = Standardized Medicare Supplement Benefit Plan

X = Includes model loadings and fees charged.

Y = Excludes Active Life Reserves.

Z = This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

APPENDIX A (CONT'D)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR _____

TYPE _____ SMSBP (P) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code_____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
	Earned			Cumulative				Cumulative		Policy Year
Year	Premium	Factor	(b) x (c)	Loss Ratio	(d) x (e)	Factor	(b) x (g)	Loss Ratio	(h) x (i)	Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(1):		(m):		(n):	

Benchmark Ratio Since Inception: (1 + n) / (k + m) :

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan.

APPENDIX A (CONT'D)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR _____

TYPE _____ SMSBP (P) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):	_____	(1):	_____	(m):	_____	(n):	_____	

Benchmark Ratio Since Inception: (1 + n) / (k + m) :

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They arethe loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and correction made to heading of form on last page of Appendix A effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2).

Appendix B. Medicare Supplement Coverage Plans

[12 point]

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:

BENEFIT PLAN(s) _____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard Plans plus two high deductible Plans. This chart shows the benefits included in each Plan. Every company must make available Plan "A". Some Plans may not be available in [your state or Arizona].

BASIC BENEFITS:	Included in all Plans.
Hospitalization:	Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses:	Part B coinsurance (Generally [20]% of Medicare approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
Blood:	First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible Plans pay the same or offer the same benefits as Plans F and J after you have paid a calendar year [$1,620] deductible. Benefits from high deductible Plans F and J will not begin until your out-of-pocket expenses are [$1,620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in Plan J, the Plan's separate prescription drug deductible or, in Plans F and J, the Plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.
[for agents] Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:] [insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each Plan prominently identified in the cover page a chart showing the services, Medicare payments, Plan payments, and insured payments for each Plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each Plan are included in this appendix. An issuer may use additional benefit Plan designations on these charts pursuant to R20-6-1106.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$0	$[812] (Part A Deductible)
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50]	$0	Up to $[101.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B (*Continued*) - Plan A

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	$100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50]	$0	Up to $[101.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B
MEDICARE (PART B)-MEDICAL SERVICES; PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts *	$0	$[100] (the Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$[100] (Part B)	$0 (Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN D
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812](Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (the Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN D
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN E
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B (*Continued*) - Plan E

PLAN E

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services, such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

FOREIGN TRAVEL - NOT COVERED BY MEDICARE

Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible Plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan F will not begin until your out-of-pocket expenses are [$1,620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible Plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan F will not begin until your out-of-pocket expenses are [$1,620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (the Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B			
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amount *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B (*Continued*) - Plan G

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN H
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B (*Continued*) - Plan H

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN I
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$[100]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B (*Continued*) - Plan I

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible Plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [$1,620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate prescription drug deductible or the Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[812]	$[812] (Part A Deductible)	$0
61st thru 90th day	All but $[203] a day	$[203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[406] a day	$[406] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	Up to $[101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible Plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [$1,620] Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the Plan's separate prescription drug deductible or the Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $$1620 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts* $0 (the Part B Deductible)		$[100]	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within eight weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed seven each week	
- Calendar year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services, such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

OTHER BENEFITS (*Continued*)

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and corrections made to Plan C (Medicare (Part B) - Medical Services - Per Calendar Year) and Plan J (Other Benefits) effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2).

APPENDIX C

[Statements]

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide whether you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. The benefits and premiums under your Medicare supplement policy can be suspended for 24 months, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?
   a. If so, with which company?
   b. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?
2. Do you have any other health insurance coverages that provide benefits similar to this Medicare supplement policy [certificate]?
   a. If so, with which company?
   b. What kind of policy?
3. Are you covered for medical assistance through the state Medicaid program:
   a. As a Specified Low Income Medicare Beneficiary (SLMB)?
   b. As a Qualified Medicare Beneficiary (QMB)?
   c. For full Medicaid Benefits?

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3).

APPENDIX D

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [company name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully, and compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify)_____

_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3).

APPENDIX E

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate Number	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2).

Appendix F. Medicare Disclosure Statements

MEDICARE DISCLOSURE STATEMENTS

Instructions for use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries

1. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

2. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person who already has a Medicare supplement policy except as a replacement policy.

3. Property/Casualty and Life insurance policies are not considered health insurance.

4. Disability income policies are not considered to provide benefits that duplicate Medicare.

5. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

6. The federal law does not preempt state laws that are more stringent than the federal requirements.

7. The federal law does not preempt existing state form filing requirements.

8. Section 1882 of the federal social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix F remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for 1 of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that pay fixed dollar amounts for a specified disease or diseases or a specified impairment or impairments. This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

This is not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for 1 of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits incurred for an accident injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the policy conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Historical Note

Appendix F adopted effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1).

ARTICLE 12. HIV/AIDS: PROHIBITED AND REQUIRED PRACTICES

R20-6-1201. Definitions

A. "AIDS" means Acquired Immune Deficiency Syndrome.

B. "Applicant" means an applicant for a life or disability insurance policy or coverage under a health care plan, as well as any potential certificate holder or dependent covered under such policy or plan.

C. "Insurer" means life and disability insurers (including but not limited to health insurers), hospital and medical service corporations, and health care services organizations, including all employees, contractors, and agents thereof.

D. "Person" means any individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, or entity.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1201 recodified from R4-14-1201 (Supp. 95-1).

R20-6-1202. Applications for Insurance

A. Insurers shall not use questions on applications for life or disability policies or health care plans that inquire directly or indirectly about:

1. The sexual orientation of an applicant;
2. An applicant's receipt of transfusions of blood or blood products; or
3. Whether or not the applicant has had any HIV-related test, except as provided in subsection (B) of this rule.

B. Insurers may include specific questions on applications for life or disability insurance policies or health care plans asking if the applicant has ever been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus. No adverse underwriting decision shall be made on the basis of any prior positive HIV-related test or tests unless the insurer has verified that the prior test(s) consisted of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be

approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturer's directions for use, including but not limited to the manufacturers' specified interpretation of positivity.

Historical Note
Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1202 recodified from R4-14-1202 (Supp. 95-1).

R20-6-1203. Testing for HIV; Consent Form

A. An insurer may test for HIV infection in the same way that the insurer tests for other conditions that affect mortality and morbidity. No adverse underwriting decision shall be made on the basis of a positive result to an HIV-related test unless the result consists of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturers' directions for use, including but not limited to the manufacturers' specified interpretation of positivity.

B. If an applicant is requested to take an HIV-related test in connection with an application for a life or disability insurance policy or a health care plan, the insurer shall reveal the use of such test to the applicant and shall obtain the written consent of the applicant prior to the administration of such test. The insurer shall allow the applicant up to 10 days within which to decide whether or not to sign the consent form, and no adverse underwriting decision may be made on the basis of the applicant's delay during this time period. Insurers need not provide pretest counseling to applicants but shall advise applicants of the availability of counseling in accordance with subsection (C) of this rule.

C. The written consent form, which shall be approved by the Director in advance of its use, shall contain the following information:

1. Purpose of the consent form. The form shall contain a clear disclosure that the test to be performed is a test for the presence of HIV antibodies, antigens, or the virus, and that underwriting decisions will be based on the results of such test. The form shall further provide notice of a period of not less than 10 days during which the applicant may decide whether or not to sign the form, along with a disclosure that the applicant's refusal to be tested may be used as a reason to deny coverage.
2. Information on HIV. The form shall provide clear, concise, and accurate information on how the disease is spread and what behavior places persons at risk of contracting the virus.
3. Pretest counseling considerations. The written consent form shall contain information advising the applicant that counseling is recommended by many public health organizations and that the applicant may obtain such counseling at the applicant's own expense. The form shall contain current information as provided by the Department regarding the availability in Arizona of free confidential or anonymous counseling through county health departments and through other governmental or government-funded agencies.
4. Disclosure of test results. The form shall advise the applicant that all test results shall be treated confidentially and that results shall be released only to the applicant and the named insurer or upon the applicant's written consent or as otherwise required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.
5. Meaning of positive test results. The form shall advise the applicant of the type of test (including but not limited to antibody, antigen, or viral culture) to be used, and that a positive test result indicates that the applicant has been infected with HIV but does not necessarily have AIDS. The form shall explain that a positive test result will adversely affect the application for insurance.
6. Consent. The consent form shall contain an attestation to be signed by the applicant or, if the applicant lacks legal capacity to consent, a person authorized pursuant to law to consent on behalf of the applicant, that he or she has read and understands the written consent form and voluntarily consents to the performance of a test for HIV and to the disclosure of the test results as described in the consent form. The applicant or the applicant's legal representative shall have the right to request and receive a copy of the written consent form. A photocopy of the form shall be as valid as the original.
7. Optional release of information to personal physician. In addition to the release of information to the insurer provided in the consent form, the applicant may, at the applicant's option, consent to the release of information to the applicant's personal physician. The form shall provide for such release to be separately signed and dated by the applicant, or if the applicant lacks legal capacity to consent, by a person authorized pursuant to law to consent on behalf of the applicant.
8. Time period during which release of information is effective. The consent form shall specify the time period during which any and all release provisions of the consent form shall be effective, but in no case shall such time period exceed 180 days from the date the consent form is signed by the applicant or the applicant's legal representative. No HIV-related information shall be released to any person after the expiration of that time period unless the insurer obtains the express written consent, pursuant to R20-6-1204, of the applicant or, if the applicant lacks legal capacity to consent, by a person authorized by law to consent on behalf of the applicant.

Historical Note
Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1203 recodified from R4-14-1203 (Supp. 95-1).

R20-6-1204. Release of Confidential HIV-related Information; Release Form

A. Except as required by law or authorized pursuant to a written consent to be tested, an insurer shall not disclose confidential HIV-related information to any person unless a written release form is executed by the applicant or, if the applicant lacks legal capacity to consent to such release, by a person authorized by law to consent to the release of information on behalf of the applicant. The applicant or the applicant's legal representative shall be entitled to receive a copy of the release. A photocopy shall be as valid as the original.

B. Such written release form shall contain the following information:

1. The name and address of the person to whom the information shall be disclosed;
2. The specific purpose for which disclosure is to be made; and
3. The time period during which the written release is to be effective but in no case shall such time period exceed 180 days from the date the release is signed by the applicant or the applicant's legal representative;

4. The signature of the applicant or of the person authorized by law to consent to such release, and the date the release form was signed.

Historical Note
Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1204 recodified from R4-14-1204 (Supp. 95-1).

R20-6-1205. Benefits; Prohibited Practices

A. Life and disability insurance policies or health care plans that provide benefits for prescription drugs shall provide benefits for any and all drugs and pharmaceutical forms of treatment for HIV and/or AIDS approved by the Food and Drug Administration pursuant to 21 U.S.C. Chapter 9 or licensed by the Food and Drug Administration pursuant to 42 U.S.C. Chapter 6A, including but not limited to Zidovudine, formerly Azidothymidine ("AZT"), Didanosine (ddI) and Zalcitabine (ddC), to the same extent as other prescription drugs and treatments.

B. Insurers shall provide benefits for HIV, AIDS, and AIDS-related conditions in the same manner and to the same extent as those benefits provided for all other diseases.

Historical Note
Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1205 recodified from R4-14-1205 (Supp. 95-1).

ARTICLE 13. RESERVED

ARTICLE 14. INSURANCE HOLDING COMPANY

R20-6-1401. Definitions

A. "Executive officer" means chief executive officer, chief operating officer, chairman of the board, president, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

B. "Foreign insurer" shall include an alien insurer except where expressly noted otherwise.

C. "Ultimate controlling person" means that person within a holding company system which is not controlled by any other person.

D. Unless the context otherwise requires, other terms found in these rules are used as defined in A.R.S. § 20-481.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 recodified from R4-14-1401 (Supp. 95-1).

R20-6-1402. Acquisition of Control – Statement Filing

A. A person required to file a statement pursuant to A.R.S. § 20-481.02 shall furnish the required information on Form A, attached hereto as Appendix A, in accordance with the instructions contained in Appendix E.

B. If the person being acquired is deemed to be a "domestic insurer" solely because it is a person controlling an insurer pursuant to A.R.S. § 20-481.02(A), the name of the domestic insurer on the cover page shall be indicated as follows: "[ABC Insurance Company), a subsidiary of [XYZ Holding Company]." Where such insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1402 recodified from R4-14-1402 (Supp. 95-1).

R20-6-1403. Annual Registration of Insurers – Statement Filing

A. An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 shall furnish the required information on Form B, attached hereto as Appendix B, in accordance with the instructions contained in Appendix E.

B. Amendments to Form B shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the change and not the date of the original filings.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1403 recodified from R4-14-1403 (Supp. 95-1).

R20-6-1404. Summary of Registration – Statement Filing

An insurer required to file an annual registration statement shall also furnish information required on Form C, attached hereto as Appendix C, in accordance with the instructions in Appendix B. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the Commissioner of that state.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1404 recodified from R4-14-1404 (Supp. 95-1).

R20-6-1405. Alternative and Consolidated Registrations

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register pursuant to A.R.S. § 20-481.09. A registration statement may include information not required by this Article regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

1. The statement or report contains substantially similar information required to be furnished on Form B; and
2. The filing insurer is the principal insurance company in the insurance holding company system.

B. An insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it is the principal insurer in the insurance holding company system.

C. With the prior approval of the Director, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (A) above.

D. Any insurer may take advantage of the provisions of this rule without obtaining the prior approval of the Director. The Director, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1405 recodified from R4-14-1405 (Supp. 95-1).

R20-6-1406. Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person, hereinafter referred to in this rule as the "subject," shall contain the following information:

1. The number of authorized, issued and outstanding voting securities of the subject;
2. The number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned by the person disclaiming control and

all affiliates, and the number of such shares concerning which there is a right to acquire, directly or indirectly;
3. All relationships and bases for affiliation between the subject and the person disclaiming control and all affiliates of such person;
4. A statement explaining why such person should not be considered to control the subject.

B. A request for termination of registration shall be deemed to have been granted unless the director, within 30 days after receiving the request, notifies the registrant otherwise.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1406 recodified from R4-14-1406 (Supp. 95-1).

R20-6-1407. Transactions Subject to Prior Notice – Notice Filing

An insurer required to give notice of a proposed transaction pursuant to A.R.S. § 20-481.12 shall furnish the required information on Form D, attached hereto as Appendix D, in accordance with the instructions in Appendix E.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1407 recodified from R4-14-1407 (Supp. 95-1).

R20-6-1408. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:
1. The amount of the proposed dividend;
2. The date established for payment of the dividend;
3. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with all explanation of the basis for valuation;
4. A copy of the calculations determining that the proposed dividend is extraordinary, including:
   a. The amounts, dates and form of payment of all dividends or distributions, including regular dividends and excluding distributions of the insurer's own securities, paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year.
   b. Surplus as regards policyholders, total capital and surplus, as of the 31st day of December next preceding;
   c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;
   d. If the insurer is not a life insurer, the net investment income, net realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-months periods; and
   e. If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.
5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and
6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus and assets relative to the insurer's financial needs.

B. Each registered insurer shall report to the Director all dividends and other distributions to shareholders within 15 business days following the declaration thereof, including the same information required by subsection (A)(4)(a) through (e) of this rule.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1408 recodified from R4-14-1408 (Supp. 95-1).

APPENDIX A

FORM A
STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

[Name of Domestic Insurer]

By

[Name of Acquiring Person (Applicant)]

Filed with the Arizona Department of Insurance

Dated: , 19

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. INSURER AND METHOD OF ACQUISITION

[State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired. State the federal identification number and the NAIC number of the domestic insurer.]

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

[(a) State the name and address of the applicant seeking to acquire control over the insurer.]

[(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.]

[(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, including NAIC numbers for all insurers. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.)

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

[The applicant if (s)he is an individual, or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual shall provide the following information as to the in affidavit form:

(a) Affiant's full name, other names used at any time, home and business addresses and telephone numbers, social security number, date and place of birth, and residences for the last 10 years;

(b) Affiant's education, including dates, names of institutions, locations and degrees awarded;

(c) Affiant's membership in professional societies and associations;

(d) Affiant's employment history for the past 20 years, including positions held, dates, employers' names and mailing addresses;

(e) Whether Affiant has ever been in a position which imposed a fidelity bond, and if so, name of the insuring company and/or place of employment, whether any claims were made on the bond, and whether Affiant has ever been denied a fidelity bond or had a bond cancelled or revoked;

(f) Any professional, occupational or vocational licenses issued to Affiant by any public or governmental licensing agent or regulatory authority presently held or held in the past, including dates licenses issued, issuer of license, date of termination and reasons for termination, and whether any such license has ever been refused, suspended or revoked;

(g) Whether Affiant controls directly or indirectly or owns legally or beneficially 1% or more of the outstanding stock of any insurer, and if so, name and type of insurer, percent of ownership, how insurer is controlled, and details related to any pledging of the stock, with or without title transfer;

(h) Whether members of Affiant's immediate family subscribe or own, beneficially or of record, shares of stock of the applicant organization or its affiliates and whether any of the shares are pledged or hypothecated in any way;

(i) Whether Affiant has been adjudged or designated a bankrupt or a debtor under the United States Bankruptcy Code, Title 11 of the United States Code;

(j) Whether Affiant has been convicted, served with a criminal summons, questioned, arrested, taken into custody, indicted, charged with, tried for or ever been the subject of an investigation concerning the violation of any law, including convictions or judgments that have been expunged, set aside, reversed or dismissed, excluding only traffic violations which resulted in a penalty not exceeding $200 and those incidents which occurred prior to the individual's 18th birthday;

(k) Whether Affiant has ever been the subject of disciplinary proceedings before any federal or state regulatory authority;

(1) Whether Affiant has ever been a management consultant, administrator, officer, director, trustee, investment committee ember, key employee or controlling stockholder of any company or company affiliate which became insolvent or was placed under supervision or in

receivership, rehabilitation, liquidation or conservatorship or had its certificate of authority suspended or revoked while you occupied such position.

Such persons shall also submit fingerprints and the fingerprint processing fee in accordance with A.R.S. § 20-481.03(B).]

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

[(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.]

[(b) Explain the criteria used in determining the nature and amount of such consideration.]

[(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.)

ITEM 5. FUTURE PLANS OF INSURER

[Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.]

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

[State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.]

ITEM 7. OWNERSHIP OF VOTING SECURITIES

[State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.]

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

[Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.]

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

[Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefore. State whether any such shares so purchased are hypothecated.]

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

[Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.)

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

[Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.]

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

[(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]

[(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.]

If the applicant is an individual and annual financial statements have not been prepared for the preceding years, the financial statements for years other than the two most recent years may consist of true and correct copies of the applicant's federal income tax returns which have been signed by the applicant(s) and filed with the Internal Revenue Service.

[(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed

employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A.)

ITEM 13. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.02 _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 _____.

(SEAL)

Name of Applicant

BY _____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorize to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX B

FORM B
INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Date: , 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

[Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the federal identification number and the NAIC number of each, the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.]

ITEM 2. ORGANIZATIONAL CHART

[Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.]

ITEM 3. THE ULTIMATE CONTROLLING PERSON

[As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

(e) The principal business of the person.

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.]

ITEM 4. BIOGRAPHICAL INFORMATION

[All persons who are directors, executive officers and/or owners of 10% or more of the voting securities of the ultimate controlling person shall provide the following information in an affidavit form:

(a) Affiant's full name, other names used at any time, home and business addresses and telephone numbers, social security number, date and place of birth, and residences for the last 10 years;

(b) Affiant's education, including dates, names of institutions, locations and degrees awarded;

(c) Affiant's membership in professional societies and associations;

(d) Affiant's employment history for the past 20 years, including positions held, dates, employers' names and mailing addresses;

(e) Whether Affiant has ever been in a position which imposed a fidelity bond, and if so, name of the insuring company and/or place of employment, whether any claims were made on the bond, and whether Affiant has ever been denied a fidelity bond or had a bond cancelled or revoked;

(f) Any professional, occupational or vocational licenses issued to Affiant by any public or governmental licensing agent or regulatory authority presently held or held in the past, including dates licenses issued, issuer of license, date of termination and reasons for termination, and whether any such license has ever been refused, suspended or revoked;

(g) Whether Affiant controls directly or indirectly or owns legally or beneficially 1% or more of the outstanding stock of any insurer, and if so, name and type of insurer, percent of ownership, how insurer is controlled, and detail related to any pledging of the stock, with or without title transfer;

(h) Whether members of Affiant's immediate family subscribe or own, beneficially or of record, shares of stock of the ultimate controlling person or its subsidiaries or affiliates and whether any of the shares are pledged or hypothecated in any way;

(i) Whether Affiant has been adjudged or designated a bankrupt or a debtor under the United States Bankruptcy Code, Title 11 of the United States Code;

(j) Whether Affiant has been convicted, served with a criminal summons, questioned, arrested, taken into custody, indicted, charged with, tried for or ever been the subject of an investigation concerning the violation of any law, including convictions or judgments that have been expunged, set aside, reversed or dismissed, excluding only traffic violations which resulted in a penalty not exceeding $200 and those incidents which occurred prior to Affiant's 18th birthday;

(k) Whether Affiant has ever been the subject of disciplinary proceedings before any federal or state regulatory authority;

(l) Whether Affiant has ever been a management consultant, administrator, officer, director, trustee, investment committee member, key employee of controlling stockholder of any company or company affiliate which became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship or had its certificate of authority suspended or revoked while Affiant occupied such position.)

ITEM 5. TRANSACTIONS AND AGREEMENTS

[Briefly describe the following agreements in force, and material transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) purchases, sales or exchanges of assets;

(3) transactions not in the ordinary course of business;

(4) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) all management agreements, service contracts and all cost-sharing arrangements;

(6) reinsurance agreements;

(7) dividends and other distributions to shareholders;

(8) consolidated tax allocation agreements; and

(9) any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving 1/2 of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.]

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

[A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.]

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

[The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.]

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

[(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the Director otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B.]

ITEM 9. FORM C REQUIRED

[A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.]

ITEM 10. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____day of _____, 19 _____.

(SEAL)

Name of Applicant

BY_____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX C

FORM C
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Date: , 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

[Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B, insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.]

SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 _____.

(SEAL)

Name of Applicant

BY _____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX D

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Date: , 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

[Furnish the following information for each of the parties to the transaction:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.]

ITEM 2. DESCRIPTION OF THE TRANSACTION

[Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under A.R.S. § 20-481.12.

(b) A statement of the nature of the transaction.

(c) The proposed effective date of the transaction.]

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

[Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

[If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of duns, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 5.REINSURANCE

[If the transaction is a reinsurance agreement or modification thereto, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.]

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

[For management and service agreements, furnish:

(a) a brief description of the managerial responsibilities, or services to be performed.

(b) a brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.]

[For cost-sharing arrangements, furnish:

(a) a brief description of the purpose of the agreement.

(b) a description of the period of time during which the agreement is to be in effect.

(c) a brief description of each party's expenses or costs covered by the agreement.

(d) a brief description of the accounting basis to be used in calculating each party's costs under the agreement.]

ITEM 7. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____on the _____ day of _____, 19 _____.

(SEAL)

Name of Applicant

BY _____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX E
INSTRUCTIONS ON FORMS A, B, C, D

Forms A, B, C, and D are intended to be guides in the preparation of the statements required by A.R.S. §§ 20-481.02 and 20-481.07. They are not intended to be blank forms which are to be filled in. The statements shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

Two complete copies of each statement including exhibits, and all other papers and documents filed as a part thereof, shall be filed with the Director by personal delivery or mail addressed to: Insurance Director of the State of Arizona, Attention: Corporate and Financial Affairs Division. A copy of Form C shall be filed in each state in which an insurer is authorized to do business, if the Director of that state has notified the insurer of its request in writing. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

Statements shall be prepared on paper 8 1/2”x 11” in size and bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

Information required by any item of Form A, Form B or Form D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Director which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Director which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:

(1) The person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and

(2) The person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there may be filed with the Director as a separate document:

(1) identifying the information, document or report in question;

(2) stating why the filing thereof at the time required is impractical; and

(3) requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Director within 60 days after receipt thereof enters an order denying the request.

In addition to the information expressly required to be included in Form A, Form B, Form C and Form D, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C or D shall include on the top of the cover page the phrase: “Change No. (insert number) to” and shall indicate the date of the change and not the date of the original filing.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1).

ARTICLE 15. RESERVED

ARTICLE 16. CREDIT FOR REINSURANCE

R20-6-1601. Credit for Reinsurance

A. The requirements of A.R.S. § 20-261.01(A)(1) through (4) shall be determined as of the date of the ceding insurer's statutory financial statement in which the credit for reinsurance is claimed as an asset to or a deduction from liability.

B. Accredited reinsurer.

1. No assuming insurer shall be an "accredited reinsurer" under A.R.S. § 20-261.01(A)(2) until it has submitted an application to the Department on a form provided by the Department and is approved by the Director.
2. An application for accreditation as a reinsurer shall include:
   a. Form AR-1. The requirement to file with the Director evidence of a reinsurer's submission to this state's jurisdiction and to submit to this state's authority to examine its books and records, as set forth in A.R.S. § 20-261.01(A)(2)(a) and (b), shall be accomplished by filing with the Director a properly executed Form AR-1, attached as Appendix A to this Article;
   b. A certified copy of a letter or a certificate of authority or a certificate of compliance as evidence that the reinsurer is:
      i. Licensed to transact insurance or reinsurance in at least one state, or
      ii. A United States branch of an alien assuming insurer, that is entered through and licensed to transact insurance or reinsurance in at least one state;
   c. A certified copy of the most recent annual statement filed with the insurance department of the reinsurer's state of domicile or entry and a copy of the most recent audited financial statement;
   d. The payment of an application filing fee in accordance with A.R.S. § 20-230; and
   e. Any other supporting documentation the Director may require.
3. The Director may examine the reinsurer's books and records as necessary for the application for accreditation, in accordance with A.R.S. §§ 20-142 and 20-156 through 20-160.
4. A reinsurer is an accredited reinsurer if, after submission of a complete application:
   a. The reinsurer maintains surplus as regards policyholders in an amount not less than $20 million, and the Director approves, or within 90 days of submission of the application, has not denied the application; or
   b. The reinsurer maintains surplus as regards policyholders in an amount less than $20 million, and the Director approves the application.
5. An accredited reinsurer shall pay its annual filing fees, in accordance with A.R.S. § 20-167, by March 1 of each year and shall file annually with the Director, the following:
   a. A certified copy of the annual statement that is filed with the insurance department of its state of domicile or entry, on or before March 1 of each year; and
   b. A copy of the most recent audited financial statement, on or before June 1 of each year.
6. The Director may revoke the accreditation of any reinsurer for cause, including failure to comply with A.R.S. § 20-261.01(A)(2) or this Section, after notice and a hearing, in accordance with A.R.S. §§ 20-161 through 20-166, and Title 41, Chapter 6, Article 10.
7. A reinsurer may surrender its accreditation only upon application to, and approval by, the Director.
8. A domestic ceding insurer for reinsurance shall not use as a credit an asset or a deduction from liability on account of reinsurance ceded under A.R.S. § 20-261.01(A)(2) if the assuming insurer's accreditation is denied, revoked, or surrendered.

C. Reinsurer domiciled and licensed in another state.

1. Substantially similar standards under A.R.S. § 20-261.01(A)(3) means credit for reinsurance standards that are equal to or exceed the standards of A.R.S. § 20-261.01 and this Section.
2. The reinsurer shall submit to this state's authority to examine the books and records of the reinsurer under A.R.S. § 20-261.01(A)(3)(b) by filing Form AR-1.

D. Reinsurer maintaining trust funds.

1. The aggregate policy holders' surplus of a group of incorporated insurers under common administration under A.R.S. § 20-261.01(A)(4)(b) shall be calculated and reported in substantially the same manner as prescribed by the Annual Statement Instructions for Property and Casualty, National Association of Insurance Commissioners, copyright NAIC 1997, and the Accounting and Practices and Procedures Manual, for Property/Casualty Insurance Companies, National Association of Insurance Commissioners, copyright NAIC 1997 Revised Edition, The Annual Statement Instructions for Life, Accident and Health, National Association of Insurance Commissioners, copyright NAIC 1997, and the Accounting Practices and Procedures Manual for Life, Accident and Health Insurance Companies, National Association of Insurance Commissioners, copyright NAIC 1997, which are all incorporated by reference and on file with the Office of the Secretary of State and available from the National Association of Insurance Commissioners, Publications Department, 120 W. 12th Street, Suite 1100, Kansas City, Missouri 64105-1925. These incorporations by reference contain no future editions or amendments.
2. The reinsurer maintaining trust funds shall submit to this state's authority to examine the reinsurer's books and records, under A.R.S. § 20-261.01(A)(4)(b), by filing Form A-1.
3. For purposes of A.R.S. § 20-261.01(A)(4)(b), the trust instrument shall expressly state that:
   a. Contested claims shall be valid and enforceable out of trust funds to the extent these claims remain unsatisfied 30 days after entry of final order of any court of competent jurisdiction in the United States.
   b. Legal title to the trust assets shall be vested in the trustee for the benefit of the reinsurer grantor's United States policyholders and ceding insurers, and any assigns of and successors in interest to the policyholders and ceding insurers.
   c. The trust is subject to examination upon the Director's request.
   d. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, within the meaning of A.R.S. § 20-261.01(A)(4)(a) and (b) has outstanding obligations under a reinsurance agreement subject to the trust.
   e. No later than February 28 of each year, the trustee shall file a written report stating:
      i. The balance in the trust;

ii. A list of the trust's investments at the preceding year-end; and
iii. A statement certifying the date of termination of the trust, if planned, or a statement certifying that the trust shall not expire before the next following December 31; and
f. An amendment to the trust is not effective unless reviewed and approved in advance by the Director.

E. For purposes of A.R.S. § 20-261.01(A)(5), "jurisdiction" means any state, district or territory of the United States or any lawful national government.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1601 recodified from R4-14-1601 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4).

R20-6-1602. Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer

For purposes of A.R.S. § 20-261.02(A)(1), monies held in trust for the ceding insurer under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder shall be so held in trust for the exclusive benefit of the ceding insurer.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1602 recodified from R4-14-1602 (Supp. 95-1).

R20-6-1603. Trust Agreements

A. As used in this Section:
1. "Beneficiary" includes any successor of the named beneficiary by operation of law, including without limitation any receiver, conservator, rehabilitator or liquidator.
2. "Grantor" means the entity that has established a trust for the benefit of the beneficiary.
3. "Obligations," as used in subsection (B)(11) of this rule, means:
   a. Reinsured losses and allocated loss expenses paid by the ceding company but not recovered from the assuming insurer;
   b. Reserves for reinsured losses reported and outstanding;
   c. Reserves for reinsured losses incurred but not reported; and
   d. Reserves for allocated reinsured loss expenses and unearned premiums.

B. Required conditions.
1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in A.R.S. § 20-261.03.
2. The trust agreement shall create a trust account into which assets shall be deposited.
3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Director's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this Section. If the Director approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subsection (B)(4)(a) of this rule must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.
4. The trust agreement shall provide that:
   a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;
   b. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;
   c. It is not subject to any conditions or qualifications outside of the trust agreement; and
   d. It shall not contain references to any other agreements or documents except as provided for under paragraph (11) of this subsection.
5. The trust agreement shall be established for the sole benefit of the beneficiary.
6. The trust agreement shall require the trustee to:
   a. Receive assets and hold all assets in a safe place;
   b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;
   c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;
   d. Notify the grantor and the beneficiary within 10 days of any deposits to or withdrawals from the trust account;
   e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and
   f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.
7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.
8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.
9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.
10. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.
11. Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:
    a. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated

loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102% of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in A.R.S. § 20-261.03 apart from its general assets, in trust for such uses and purposes specified in subparagraphs (a) and (b) above as may remain executory after such withdrawal and for any period after the termination date.

12. The trust agreement shall provide that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the type permitted by A.R.S. Title 20, Chapter 3 or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The trust agreement shall further specify the types of investments to be deposited.

C. Permitted conditions

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.
2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.
3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in subsection (D)(1)(b) of this rule.
4. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously with, other specified assets.
5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Additional conditions applicable to reinsurance agreements entered into in conjunction with trust agreements.

1. A reinsurance agreement entered into in conjunction with a trust agreement and the establishment of a trust account may contain provisions that:

a. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

b. Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by A.R.S. Title 20, Chapter 3 or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited;

c. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

d. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

e. Stipulate that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

i. To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

ii. To reimburse the ceding insurer for their assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

iii. To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agree-

ment. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses and unearned premium reserves; and

iv. To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

f. Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

ii. After withdrawal and transfer, the market value of the trust account is no less than 102% of the required amount.

iii. The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

g. Provide for:

i. The return of any amount withdrawn in excess of the actual amounts required for subsections (D)(1)(e)(i), (ii) and (iii), or in the case of subsection (D)(1)(e)(iv), any amounts that are subsequently determined not to be due; and

ii. Interest payments, at a rate not in excess of the prime rate of interest of the trustee, on the amounts held pursuant to subsection (D)(1)(e)(iii).

h. Permit the award by any arbitration panel or court of competent jurisdiction of:

i. Interest at a rate different from that provided in subparagraph (g)(ii),

ii. Court or arbitration costs,

iii. Attorney's fees, and

iv. Any other reasonable expenses.

E. Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the Director in compliance with the provisions of this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

F. Existing agreements. Notwithstanding the effective date of this rule, any trust agreement or underlying reinsurance agreement in existence and approved by the Director prior to the effective date of this rule will continue to be acceptable until December 31, 1993, after which time the agreements will have to be in full compliance with the requirements of this rule for the trust agreement to be acceptable.

G. Effect of failure to identify beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (A) of this rule shall not be construed to affect any actions or rights which the Director may take or possess pursuant to the provisions of the laws of this state.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1603 recodified from R4-14-1603 (Supp. 95-1).

R20-6-1604. Letters of Credit

A. For purposes of A.R.S. § 20-261.02, a letter of credit shall contain an issue date, and an expiration date subject to the "evergreen clause" in subsection (D) of this Section. The letter of credit shall state that:

1. The beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented for payment;
2. The letter of credit is not subject to any conditions or qualifications not contained in the letter of credit; and
3. The letter of credit does not contain reference to any other agreements, documents, or entities, except as provided in subsection (H)(1). As used in this Section, "beneficiary" includes any successor of the named beneficiary by operation of law, including any receiver, conservator, rehabilitator, or liquidator.

B. The heading of the letter of credit may include a boxed section for use by the issuing bank, which contains the name of the applicant and other notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that the information is for internal purposes only.

C. A letter of credit shall state that the obligation of a qualified United States financial institution under the letter of credit is not contingent upon reimbursement.

D. The term of the letter of credit shall be for no less than one year, and the letter of credit shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for no less than 30 days' notice before expiration or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of any state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, 1993 Revision (Publication 500) incorporated by reference and on file with the Office of the Secretary of State and available from ICC Publications, 156 Fifth Avenue, New York, New York 10010. This incorporation by reference contains no future additions or amendments. All drafts of letters of credit drawn according to Publication 500 shall be presentable at an office in the United States of a qualified United States financial institution.

F. A letter of credit made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce shall specifically provide for an extension of time to draw against the letter of credit if one or more of the occurrences specified in Article 17 of Publication 500 occur.

G. If the letter of credit is issued by a financial institution other than a qualified United States financial institution as defined in A.R.S. § 20-261.03, then the letter of credit shall be confirmed by a qualified United States financial institution, and the following additional requirements shall be met:

1. The financial institution issuing the letter of credit shall designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts of the letter of credit, and
2. The letter of credit shall contain an "evergreen clause."

H. Reinsurance agreement provisions.

1. The reinsurance agreement for which the letter of credit is obtained may:

a. Require the assuming insurer to provide a letter of credit to the ceding insurer and specify what it covers.

b. Stipulate that the letter of credit provided by the assuming insurer under the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement. The agreement shall be used by the ceding insurer or its successors in interest only for the following:
   i. To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of the policies reinsured under the reinsurance agreement because of cancellation of the policies;
   ii. To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid policy owners and claimants by the ceding insurer under the policies reinsured under the reinsurance agreement;
   iii. To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement. The amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, and unearned premium reserves; and
   iv. To pay any other amounts the ceding insurer claims under the reinsurance agreement.

c. Require that the provisions of subsections (H)(a) and (b) be applied without diminution because of insolvency of the ceding insurer or assuming insurer.

2. Nothing contained in subsection (H)(1) precludes the ceding insurer and assuming insurer from providing:
   a. An interest payment, at a rate not in excess of the prime rate of interest of a qualified United States financial institution as defined in A.R.S. § 20-261.03 issuing or confirming the letter of credit, on the amount held under subsection (H)(1)(b)(iii); and
   b. The return of any amount drawn on a letter of credit which is in excess of the actual amount due or, in the case of subsection (H)(1)(b)(iv), any amount not payable.
3. If an insurer obtains a letter of credit in conjunction with a reinsurance agreement that covers risks other than life, annuities, and health, and it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may state, instead of subsection (H)(1)(b)(iv) that the parties enter into a "Trust Agreement." The trust agreement may be incorporated into the reinsurance agreement or it may be a separate document.

I. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in a financial statement required to be filed with the Director unless a letter of credit naming the filing ceding insurer as beneficiary is issued on or before December 31 in the year for which the filing of the financial statement is made. The reduction in liability for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation the reinsurance agreement secures.

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1604 recodified from R4-14-1604 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4).

R20-6-1605. Other Security
A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1605 recodified from R4-14-1605 (Supp. 95-1).

R20-6-1606. Reinsurance Contract
Credit shall not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of R20-6-1601 or R20-6-1602 of this Article or otherwise in compliance with A.R.S. § 20-261.01 after the adoption of this Article unless the reinsurance agreement:
1. Includes a proper insolvency clause pursuant to A.R.S. § 20-261(C); and
2. Includes a provision pursuant to A.R.S. § 20-261.01(A)(6) and (B) when applicable whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1606 recodified from R4-14-1606 (Supp. 95-1).

R20-6-1607. Contracts Affected
All new and renewal reinsurance transactions entered into after the effective date of this rule shall conform to the requirements of A.R.S. § 20-261.01 and this Article if credit is to be given to the ceding insurer for such reinsurance.

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1607 recodified from R4-14-1607 (Supp. 95-1).

EXHIBIT A
FORM AR-1 - POWER OF ATTORNEY AND CERTIFICATE OF ASSUMING INSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement(s) with one or more insurers domiciled in

_____, hereby certify that
(name of state)
_____ ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in

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

2. Designates the Director of Insurance of the State of Arizona, and his or her successor or successors in office, to be its true and lawful attorney in and for the State of Arizona, upon whom all lawful process in any action, suit or legal proceeding against it, including any such action, suit or proceeding instituted by or on behalf of any ceding insurer domiciled in the State of Arizona, may be served.

   It hereby further agrees that any lawful process against it, which is served upon and forwarded by said attorney by registered mail to the person last so designated by it to receive process, shall be of the same legal force and validity as if served personally upon it, and shall be deemed sufficient service, and that the appointment and authority of said attorney shall continue so long as any of its liability remains outstanding in said state, and that its removal from said state or dissolution shall not take away or impair the right to commence any action or legal proceeding against it, in the manner herein provided, upon a liability previously incurred.

   It hereby further agrees that when any lawful process against or affecting it is served upon said Director of Insurance, a copy of said proceedings shall be mailed to:
   _____
   _____
   _____

3. Submits to the authority of the Insurance Director of Arizona
   _____to examine its books and records
   (ceding insurer's state of domicile)
   and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in
   _____reinsured by Assuming Insurer and
   (ceding insurer's state of domicile)
   undertakes to submit additions to or deletions from the list to the Insurance Director at least once per calendar quarter.

   The _____ in accordance with the resolution of its Board of Directors duly passed on _____ (a certified copy of which is attached hereto and made a part hereof) has to these presents affixed its corporate seal and cause the same to be subscribed by its President, and attested by its Secretary, at the City of _____ in the State of _____
   on this _____ day of _____ 19_____.

   _____, President

   _____, Secretary

State of _____)
) S.S.
County of _____)

On this _____day of _____, 19____, before me, _____ the undersigned officers, personally appeared _____President, and _____ _____ Secretary, who acknowledged themselves to be the President and Secretary respectively, of _____a corporation, and that they as such President and Secretary, respectively, being authorized to do so, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by the President, attested by the Secretary, and affixing the corporate seal thereto.

IN WITNESS WHEREOF I hereto set my hand and official seal.

_____
Notary Public

(Seal) Commission expires: _____

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1)

EXHIBIT B
CERTIFIED COPY OF RESOLUTION

At a meeting of the Board of Directors of this _____ (full and exact corporate name) held
on the _____ day of_____, 19_____, at its office, a quorum of said Board was present, and, on motion, the following resolution was duly passed by said Board:

RESOLVED, that this

_____
(full and exact corporate name)

hereby authorizes its President and Secretary, under its corporate seal, to irrevocably appoint the Director of Insurance of the State of Arizona, and his or her successor or successors in office, its true and lawful attorney in and for the State of Arizona, upon whom all lawful process in any action, suit or legal proceeding against it, including any such action, suit or proceeding instituted by or on behalf of any ceding insurer domiciled in the State of Arizona, may be served.

It hereby further agrees that any lawful process against it, which is served upon and forwarded by said attorney by registered mail to the person last so designated by it to receive process, shall be of the same legal force and validity as if served personally upon it, and shall be deemed sufficient service, and that the appointment and authority of said attorney shall continue so long as any of its liability remains outstanding in said state, and that its removal from said state or dissolution shall not take away or impair the right to commence any action or legal proceeding against it, in the manner herein provided, upon a liability previously incurred.

And that it hereby further agrees that when any lawful process against or affecting it is served upon said Director of insurance, a copy of said proceedings shall be mailed to:

_____

_____

_____

And that it hereby further agrees that its President and Secretary are authorized and instructed to execute and deliver in its name and on its behalf, a Power of Attorney and Certificate of Assuming Insurer, in accordance with this resolution.

* * * * * *

I hereby certify that the above is a correct copy of the resolution of the Board of Directors of the said

_____
(full and exact corporate name)

(Seal)

_____
Secretary

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1).

ARTICLE 17. EXAMINATIONS

R20-6-1701. Definitions

A. "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Director.

B. "Examination" shall be defined for purposes of this Article to mean any examination relating to the financial condition of a company.

C. "Examiner" means any individual or firm having been authorized by the Director to conduct an examination under this Article.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 recodified from R4-14-1701 (Supp. 95-1).

R20-6-1702. Authority, Scope, and Scheduling of Examinations

A. The Director or any of the Director's examiners shall, at a minimum, conduct an examination of every domestic insurer not less than once every three years, except that life and disability reinsurers defined in A.R.S. § 20-1082, service companies defined in A.R.S. § 20-1095, and mechanical reimbursement reinsurers defined in A.R.S. § 20-1096 shall be examined not less than once every five years. The Director or any of the Director's examiners shall examine every other insurer licensed in this state not less frequently than once every five years.

B. After January 1, 1994, the Director shall not accept in lieu of an examination under this Article an examination report on any foreign or alien insurer prepared by the insurance regulatory authority of another state unless:

1. Such insurance regulatory authority was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or
2. The examination was performed under the supervision of an accredited insurance regulatory authority or with the participation of one or more examiners who are employed or contracted by such an accredited insurance regulatory authority and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance regulatory authority.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended effective October 27, 1993 (Supp. 93-4). R20-6-1702 recodified from R4-14-1702 (Supp. 95-1).

R20-6-1703. Conduct of Examinations

A. Upon determining that an examination should be conducted, the Director or the Director's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination.

B. Nothing contained in this Article shall be construed to limit the Director's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state or to pursue such action concurrent with the examination.

C. The Director may disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country or to law enforcement officials of this or any other state or agency of the federal government at any time. Prior to making such disclosure, the Director may require such other department or office to agree in writing to hold as confidential the examination report, preliminary examination report or results or any matter relating thereto until such time as the examination report, preliminary examination report or results or matter relating thereto are made public by the Director.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1703 recodified from R4-14-1703 (Supp. 95-1).

R20-6-1704. Examination Reports

A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find warranted from the facts.

B. No later than 60 days following completion of the examination, the examiner in charge shall submit to the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not less than 10 days nor more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

C. Within 30 days after the end of the period allowed for the receipt of written submissions or rebuttals, the Director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and shall:

1. File the examination report as submitted or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Director, the Director may order the company to take any action necessary and appropriate to cure such violation; or
2. Reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and resubmission pursuant to subsection (B).

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1704 recodified from R4-14-1704 (Supp. 95-1).

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS

R20-6-1801. Definitions

In this Chapter, the following definitions apply:

"Appointment" means a first-available, initial, non-emergent, diagnostic visit to a dentist.

"Board certified" means a dentist who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association.

"Board eligible" means a dentist who successfully completes an approved training program in a specialty field recognized by the American Dental Association.

"Chief executive officer" means the person who has the authority and responsibility for the operation of a prepaid dental plan Organization according to applicable legal requirements and policies approved by the governing authority.

"Dental hygienist" means a person who is licensed to practice dental hygiene under A.R.S. § 32-1281 et seq.

"Dentist" means a person who is licensed to practice dentistry under A.R.S. § 32-1201 et seq.

"Department" means the Arizona Department of Insurance.

"Diagnostic service" means a dental service intended to identify a dental abnormality, and includes a radiograph and a clinical exam.

"Director" means the director of the Arizona Department of Insurance.

"Emergency dental service" means a dental service intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

"General dentist" means a dentist whose practice is not limited to a specific area and who is not board certified.

"Governing authority" means the persons, including a board of trustees or board of directors, who have the ultimate authority and responsibility for the direction of a prepaid dental plan Organization.

"Organization" means a prepaid dental plan organization as defined in A.R.S. § 20-1001.

"Patient" means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.

"Preventive service" means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, routine prophylaxis, and application of fluorides.

"Prophylaxis" means cleaning the teeth of a patient with healthy tissue using mild abrasives and dental instruments to remove plaque, calculus, and stains above the gum line.

"Provider directory" means an Organization's published listing of all contracted network dentists.

"Radiograph" means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray.

"Restorative service" means the use of a metal or composite filling or crown.

"Specialist" means a dentist whose practice is limited to one of the nine specialty categories recognized by the American Dental Association: endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, oral pathology, or dental public health.

"Treatment plan" means a statement of the services to be performed to eliminate or alleviate a patient's symptoms or disease, based on a dentist's assessment of the patient's dental history, the clinical examination, and the dentist's diagnosis.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1802. Application for Certificate of Authority

A. A person who wishes to operate as prepaid dental plan organization in Arizona shall file an application for certificate of authority under A.R.S. § 20-1003 for the director's review and approval under A.R.S. § 20-1004. The application shall contain all the information required in A.R.S. § 20-1003 and R20-6-1802.

B. An authorized insurer shall issue the fidelity bond required under A.R.S. § 20-1004(A)(4).

C. An Organization shall not commence operation of, or service under, a prepaid dental plan without approval of the director under A.R.S. § 20-1004.

D. An application is deemed filed with the director when the director receives it. The applicant shall include fees under A.R.S. § 20-167 with the application.

E. An applicant not domiciled in this state shall file a power of attorney as required by A.R.S. § 20-1003(A)(11) on a Department-prescribed form, with the application.

F. Within 180 days after the director issues a certificate of authority to an Organization, the Organization shall notify the director in writing of each member appointed to the board of directors for the Organization under A.R.S. § 20-1003(A)(4).

G. At the time it submits its application for certificate of authority, an Organization shall submit a written program of compliance with supporting documents that specify how the Organization will comply with the provisions of this Article. The written program of compliance shall contain the following:

1. The responsibilities of and qualifications for the following positions:
   a. The Organization's chief executive officer, and
   b. The Organization's dental director;
2. A plan for provision of basic dental services required under R20-6-1806(A) and a copy of the schedule of benefits required under R28-6-1806(B);
3. A description of the system for delivery of services under R20-6-1807;
4. A description of the geographic area designated under R20-6-1808;
5. A plan for compliance with contract requirements under R20-6-1809 and a copy of a contract with a general dentist and a specialist;
6. A plan for compliance with records requirements under R20-6-1810; and
7. The Organization's quality improvement plan under R20-6-1811.

H. An application shall include the following information:

1. The proposed number of members, and
2. A copy of a letter from each network dentist that documents the dentist's intent to contract with the Organization to provide services to patients under the Organization's prepaid dental plan.

I. The director may require that an applicant for a certificate of authority under A.R.S. § 20-1003(A)(14) submit information that discloses biographical, employment and business financial history, criminal activity, fingerprints, or any information that relates to the ability to operate a prepaid dental plan for principals, principal officers, controlling persons, and insurance producers of the applicant, if necessary for the protection of residents of this State.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1803. Chief Executive Officer

A. The governing authority shall appoint a chief executive officer (CEO). The CEO shall have:

1. The education and experience to manage the Organization, and
2. Responsibility for the geographic area in Arizona that the Organization serves, including:
   a. Implementing the policies of the governing authority, and

b. Maintaining adequate personnel to ensure compliance with applicable Arizona statutes and rules.

B. The governing authority shall notify the Department within ten days after the effective date of a change in the appointment of the CEO.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1804. Dental Director

A. The governing authority or CEO shall appoint as the Organization's dental director a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia.

B. The dental director shall perform at least the following functions for the Organization's geographic area in Arizona:
1. Participate on the Organization's quality improvement committee required under R20-6-1811;
2. Oversee the Organization's program and processes for:
   a. Maintaining and improving clinical quality of care, including continuity of care;
   b. Provider relations;
   c. Facility and dental record reviews; and
   d. Provider credentialing and recredentialing;
3. Be knowledgeable about and participate in decisions regarding the Organization's operations;
4. Comply with A.R.S. § 20-2510(B) and (C) when directly denying, on the basis of medical necessity, a health care provider's request for prior authorization; and
5. Timely respond to matters within the Organization's Arizona geographic area that require personal onsite attention or ensure that a designee who meets the requirements specified in subsection (D) timely responds to those matters.

C. Matters that require personal onsite attention include:
1. Urgent patient care issues that require examination of dental records or X-rays;
2. Prompt personal discussion with a provider of urgent concerns relating to credentialing, disciplinary problems, access to care, or quality of care.

D. Any designee acting under subsection (B)(5) shall:
1. Be a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia;
2. Have expedient access to the dental director, the CEO, and other organization management personnel as necessary to resolve any matter requiring personal onsite attention; and
3. Have the education, experience, and Organizational knowledge required to address the matter requiring personal onsite attention.

E. The Organization shall notify the Department in writing within ten days after the effective date of a change in the appointment of the dental director or any designee.

F. The requirements for a designee under subsections (B)(5), (D), and (E) shall not apply to an Organization with fewer than 2,000 members in Arizona.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1805. Required Reporting

A. An Organization shall submit to the Department in writing for review any proposed change to the program of compliance. The Department shall notify the Organization in writing within 30 days of receipt of the proposed change whether the submission is administratively complete. The Department shall complete its substantive review and notify the Organization of approval or disapproval of the proposed change within 60 days of notification of administrative completeness.

B. An Organization shall provide the following information about the prepaid dental plan to the Department quarterly:
1. The total number of members and the number of members assigned to each general dentist's office;
2. A list of all contracted network general dentists and specialists that notes those who have been added or deleted since the previous quarterly report;
3. Verification that each specialist added to the network since the last quarterly report has graduated from a specialty graduate program accredited by the American Dental Association; Documentation of the Organization's quality improvement activities, including the number of providers who have been credentialed or re-credentialed since the last quarterly report, the number of facility reviews, and the number of chart reviews;
4. The average wait time measured in weeks for an appointment for each network dentistry office;
5. A copy of the current provider directory; and
6. A complaint log with a summary of Organization responses by complaint category.

C. An Organization shall submit the following information to the Department at least annually:
1. Member satisfaction survey results and supporting data;
2. Results of a survey of network general dentistry offices with supporting data confirming a recall system under R20-6-1809(B)(2);
3. An electronic database that lists the name, address, and telephone number of each provider and whether the provider is accepting new members. The Organization shall submit the database for general dentists and specialists separately. The Organization shall submit any changes to this database to the Department quarterly; and
4. A report that compiles all the copays listed in all the schedules of benefits offered by the Organization, with comparisons of the copays to the usual, customary, and reasonable fees, as determined by the Organization, for the procedures listed on the schedule of benefits.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1806. Basic Dental Services

A. A prepaid dental plan shall provide the basic dental services listed below:
1. Emergency dental services on a 24-hour-per-day basis,
2. Diagnostic services,
3. Preventive services, and
4. Restorative services.

B. An Organization shall publish and make available to its members and purchasers a schedule of benefits that includes the dental plan's basic dental services and other available dental services and any associated copays.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1807. System for Delivery of Services

A. An Organization shall have a system for delivery of services that includes:
1. An adequate network of general dentists. To determine network adequacy, the Department shall consider the following:

a. Geographic distribution of network general dentists' offices,
b. The number of dental offices accepting new members,
c. The percentage of all network members who are able to schedule an appointment within nine weeks,
d. The availability of trained clinical support staff in the Arizona geographic area,
e. The ratio of population growth to the increase or decrease in the number of dentists in the Arizona geographic area, and
f. Current availability for appointments in all general dentist practices in Arizona; and

2. Provision for using specialists for dental services that cannot be provided by the Organization's network of contracted specialists, if the services are covered benefits.

B. If a network dental office that is open to new members has an appointment wait time of longer than nine weeks, for three consecutive calendar quarters, the director may require the Organization to close the office to new members until the wait time is less than nine weeks.

C. If more than 15% of the network offices that are open to new members have an appointment wait time of longer than nine weeks, the Organization shall submit a plan to the Department under which the Organization will, within 90 days, reduce the wait time to less than nine weeks. If the Organization does not reduce the wait time to less than nine weeks within the 90 day period the Organization shall refer the members who are waiting for an appointment to another network general dentist or a non-network general dentist who can schedule the member for an appointment in less than nine weeks. The member may choose to continue dental care under the prepaid dental plan with the referred dentist for the remainder of the member's enrollment period. The Organization shall provide the non-network services to the referred member at a cost that is no greater than if the services are provided by the member's assigned network dentist.

D. An Organization shall pay for emergency dental services provided to a member by a dentist licensed in the jurisdiction where the services are provided, subject to plan limitations disclosed in the dental care plan, including emergency dental services that occur:

1. Within the geographic area served by the member's designated provider but the provider is unavailable, or
2. Occurs outside of the member's designated geographic service area.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1808. Geographic Areas

A. An Organization shall designate the geographic areas in Arizona in which the Organization intends to provide dental services that are reasonably convenient to the prospective members. The Organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany or be included in any advertisements or sales materials provided to prospective employer groups and prospective members.

B. An Organization shall define its geographic areas by citing at least one of the following:

1. Local government jurisdictions, such as cities or counties;
2. Street boundaries; or
3. Area within a specified radius of an intersection.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1809. Contract Requirements

A. An Organization shall have a written contract with each provider that documents the requirements for providing services under the prepaid dental plan and the terms of the agreements between the parties. The Organization shall ensure that the provider complies with all contract requirements.

B. In addition to the requirements in subsection (A), an Organization shall ensure that its contract with a provider includes the following provisions:

1. That the Organization has authority to review the provider's records,
2. That the provider is responsible to implement and maintain a process to inform assigned members of the need to schedule periodic preventive dental services based on the member's oral health status, and
3. That the provider is responsible to complete any procedure undertaken upon a member if the contract is terminated or expires.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1810. Records

A. Dental records are the property of the provider and shall not be removed from the provider's possession, except:

1. With the patient's permission, including for routing records to a dental or medical practitioner for consultation or evaluation; or
2. When subpoenaed by a court or BODEX.

B. An Organization shall maintain at its principal office a copy of each issued or delivered advertising matter or sales material, letter of solicitation, evidence of coverage, provider directory, certificate, agreement, or contract. The Organization shall note the date each advertising matter or sales material is filed with the Department and the date of distribution to any person. The advertising matter or sales material shall be maintained for at least three years.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1811. Quality Improvement

A. An Organization shall have a governing authority.

B. The governing authority shall appoint a quality improvement committee that consists of the chief executive officer or designee, the dental director, the person who manages the Organization's quality improvement process, and at least one dental health professional. The committee may also include network allied health professionals and members of the plan.

C. The quality improvement committee shall:

1. Meet at least quarterly,
2. Review and evaluate dental services delivered under the Organization's plan, and
3. Establish procedures for recordkeeping and distribution of committee reports.

D. An Organization shall provide the director with a copy of the minutes of each quality improvement committee meeting within 30 days of the quality improvement committee meeting.

E. An Organization shall maintain a written quality improvement plan that contains procedures for each of the following:

1. Ensuring that a dentist licensed in any state or territory of the United States or District of Columbia reviews and

evaluates dental care and services provided by each contracted general dentist at least once every three years;
2. Allocation of the Organization's resources to analyze a problem or any identified deficiency;
3. Implementing a corrective action plan and methods for monitoring improvement;
4. Notifying a member in writing of the member's responsibility to cooperate with those providing dental care services and of the member's rights to:
   a. Voice concerns about the Organization or care provided;
   b. Be provided with information about the Organization, its services, providers, and member rights and responsibilities;
   c. Participate in decisions about the member's dental care; and
   d. Be treated with respect and have the right to privacy recognized;
5. Monitoring and improving membership satisfaction;
6. Maintaining an accurate provider directory that meets at least the following requirements:
   a. Lists only credentialed providers who are currently scheduling members for diagnosis and treatment; and
   b. Clearly designates providers who are not accepting new members;
7. Review by the dental director of the following for initial credentialing of network providers:
   a. Query to the National Practitioner Data Bank;
   b. Query to BODEX;
   c. Valid United States Drug Enforcement Administration certificate, if applicable;
   d. Evidence of current malpractice insurance; and
   e. Documentation that each specialist has graduated from an accredited specialty graduate program as required by BODEX.
8. Recredentialing, at least every three years, that updates information obtained in subsections (E)(7)(b) through (d), for the dental director's review.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1812. Confidentiality of Records
An Organization shall not disclose information obtained pertaining to the diagnosis, treatment, or health of a member to any person except:
1. To the extent necessary to carry out this Article;
2. Upon the express written consent of the member, applicant, provider, or Organization, as appropriate; or
3. Under statute or court order for the production or discovery of evidence or as part of a civil or criminal investigation.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1813. Assignment of Members
A. Within 30 days of enrollment, an Organization shall assign a member to the provider the member chooses. The Organization, however, shall choose and assign a provider to a member within 30 days of any of the following:
   1. Receipt of a member enrollment form that does not designate a provider, or receipt of a member enrollment form that designates a provider who is unavailable;
   2. The date of the notice that the member's assigned provider intends to cease providing services; or
   3. The date the member's assigned provider becomes unavailable, for any reason.

B. An Organization shall give each member the option of selecting a network provider other than the provider assigned by the Organization under subsection (A).

C. An Organization shall maintain a continuous assignment process in compliance with subsection (A) and (B), allowing no more than 4% of members to be unassigned at any time.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

R20-6-1901. Applicability
A. These rules apply to all proposed and existing health care services organizations (HCSOs).

B. The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.

C. An existing HCSO shall not be required to re-file all information already on file with the Department, but it shall modify its operations and procedures as may be necessary to comply with this Article and file all additional information necessary to make statements complete and current.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1902. Definitions
In this Article, the following definitions apply:

"Chief executive officer" means the person who has the authority and responsibility for the operation of the health care services organization in accordance with applicable legal requirements and policies approved by the governing authority.

"Department" means the Department of Insurance.

"Governing authority" means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the health care services organization is vested.

"HCSO" means a health care services organization.

"Primary care" means initial treatment or screening of enrollees.

"Primary care physician" means a general practitioner, family physician, internist or pediatrician.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1903. Documentation
The chief executive officer (CEO) shall ensure that the HCSO's policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1904. Service Agreements

The HCSO shall have a written service agreement with each primary care physician who provides services on a continuing basis, except for HCSO employees, that specifies the terms and conditions for services provided to the HCSO.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1905. Examination and Review

The Director may inspect an HCSO facility and the facility of any primary care physician with whom the HCSO contracts for services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1906. Health Care Plan

A. The applicant shall submit a statement to the Department that describes the proposed health care plan, facilities, and personnel.

B. The HCSO shall have an organized system for the delivery of health care services contained in subsection (F) of this Section that includes the following:
1. Physicians, registered nurses and other professional and technical personnel who provide services under the plan;
2. Procedure that promotes a continuing relationship between an enrollee and the same primary care physician; and
3. A procedure for referrals that ensures continuity of care to enrollees.

C. The HCSO shall list:
1. The proposed or actual enrollment;
2. The number and names of physicians that will serve the enrollees and the board eligibility or certification of each physician, if any;
3. The number and type of support staff that will serve enrollees; and
4. The plan for providing specialty medical services to enrollees.

D. All care provided by the HCSO, whether provided by its own personnel or on a contract basis, shall be by a licensed:
1. Practitioner of the healing arts;
2. Health care institution; or
3. Clinical laboratory.

E. The health care services described in subsections (F)(1), (2), (3), and (6) of this Section shall be provided seven days per week, and 24 hours per day.

F. The health care plan shall provide, within the geographic area served, at least the following basic health care services that shall be covered by the monthly charges set forth in the evidence of coverage:
1. Emergency care that includes emergency services defined in A.R.S. § 20-2801(3);
2. Inpatient general hospital care;
3. Physician care that includes necessary diagnostic and therapeutic services provided by a person who has a current, and valid Arizona license to practice medicine and surgery;
4. Outpatient care that includes preventive, diagnostic, and therapeutic services, including primary care, furnished by, or under the direction of, a physician, laboratory, or radiology services. Primary care may include services provided by the following:
   a. A physician's assistant who has a current and valid registration under the applicable provisions of A.R.S. Title 32, Chapters 13, 17 and 25, to provide patient services as specified in the job description or approved program; or
   b. A registered nurse certified by the Arizona State Board of Nursing, to function in specialty areas under A.R.S. § 32-1601(B)(6).
5. Health maintenance care designed to prevent illness and to improve the general health of enrollees, offered when medically necessary or indicated that shall include the following:
   a. Immunizations;
   b. Health education; and
   c. Periodic health examinations, excluding certified health examinations for insurance qualification, school attendance, and employment. The periodic examinations shall include screening for vision and hearing and shall be offered when medically necessary or indicated, and on at least on the following schedule:
      i. Enrollees aged 0 - 1 year – one exam every four months
      ii. 2 - 5 years – one exam every year
      iii. 6 - 40 years – one exam every five years
      iv. 41 - 50 years – one exam every three years
      v. 51 - 60 years – one exam every two years
      vi. 61 years and over – one exam every year
      vii. A medical history and health examination offered to each new enrollee within 12 months after enrollment.
6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.

G. The HCSO shall provide appropriate coverage for out-of-area emergency care to enrollees when traveling outside the area served by the HCSO.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1907. Geographic Area

A. The applicant shall submit a statement that describes the geographic area in which it will provide services that are reasonably convenient to prospective enrollees.
1. The applicant shall attach a map to the statement that describes the boundaries of the proposed geographic area and the location of each facility in which primary care will be provided under the plan; and
2. The applicant shall describe the proposed geographic area in at least one of the following ways:
   a. Legal description;
   b. Local governmental jurisdiction such as city or county;
   c. Census tracts;
   d. Street boundaries; or
   e. Area within a specified radius of a specified intersection, or a specified primary care center.

B. All advertising matter and sales material provided to prospective enrollees shall include a description of the geographic area in terms readily understandable by the general public.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1908. Chief Executive Officer

A. The governing authority shall appoint a CEO who shall have appropriate education and experience to manage the HCSO.

The governing authority shall define the authority and duties of the CEO in writing. The CEO shall be the appointed representative of the governing authority and shall be the executive officer of the HCSO.

B. The CEO shall have at least the following duties and responsibilities:
1. Management of the HCSO;
2. Establish and implement policies and procedures of the HCSO;
3. Act as liaison between the governing authority and the providers of health care and other services to the HCSO; and
4. Establish a written plan of authority that will be in place in the CEO's absence.

C. When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.

D. The HCSO shall assure that all HCSO employees and health practitioners covered by service agreements are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.

E. The HCSO shall designate a central place of business within the major geographic area served at which the CEO shall be based and from which the HCSO shall direct administrative activities.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1909. Medical Director

A. The HCSO shall designate a physician as medical director.

B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO, if the medical director has appropriate education and experience to manage the HCSO.

C. The medical director's responsibilities shall include:
1. Supervision of medical staff;
2. Performance planning and evaluation of staff;
3. Coordination of activities of medical staff; and
4. Development of medical care policies.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1910. Medical Records

A. The HCSO shall maintain a medical record system that is capable of readily providing necessary information and assures continuity of enrollee care.

B. The HCSO shall maintain a centralized medical record in accordance with acceptable professional standards. The record shall include records that detail all symptoms presented, diagnoses made and medical treatment the HCSO provided to each enrollee during the term of enrollment. This requirement applies to all HCSO services provided to enrollees, whether provided by employees of the HCSO or non-employees at the request of the HCSO.

C. The HCSO shall designate a person to be generally responsible for administration of records.

D. The HCSO shall ensure that medical records are kept confidential and that only authorized personnel shall have access to the records.

E. Medical records shall not be removed from the premises where they are filed, except by subpoena, court order, or written permission or request of the patient who is the subject of the records. The HCSO may route the record, including x-ray film, to practitioners of the healing arts for consultation or evaluation.

F. Under A.R.S. § 20-1058(D) and A.R.S. § 20-1064, the HCSO shall make records available for review by the Director or representatives of the Director. During routine surveys, the Department representatives shall review medical records of the HCSO on a random sample basis or upon complaint or special investigations, specific medical records may be reviewed.

G. The HCSO shall ensure that complete records are preserved for at least 10 years. If the enrollee is a minor, the record shall be maintained for at least two years after the enrollee has reached majority.

H. If an enrollee discontinues enrollment in the HCSO, the HCSO shall furnish, to the enrollee, upon written request, a written summary covering all pertinent phases of health care provided during enrollment. The summary shall include a copy of pertinent reports and results of diagnostic tests that might be used for comparative purposes, a record of immunizations and the last periodic health examination to another provider of health care services, as specified by the enrollee. This summary shall be furnished within 30 days after the enrollee requests disenrollment. The HCSO may charge a reasonable fee for the summary, based upon the cost of providing it.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

R20-6-1911. Quality Assurance

A. The HCSO shall provide an effective method for a continuing review and evaluation of the health care provided to ensure that treatment and level of care were appropriate and adequate, that the quality of health care provided met acceptable standards, and that corrective action occurred or will occur, if indicated.

B. The HCSO shall have a quality assurance committee that includes at least the chief executive officer, or designee, the medical director, practitioners of the healing arts, and allied health professionals. Services performed by practitioners of the healing arts shall be reviewed and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and dissemination of the reports.

C. The HCSO shall have a quality assurance that includes procedures to be used for each of the following:
1. Establishment of standards for health care;
2. Monitoring of care provided;
3. Analysis of problems identified;
4. Correction of deficiencies including a time schedule for correction and a link to a continuing education program; and
5. Follow-up and periodic reassessment of the plan.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

ARTICLE 20. CAPTIVE INSURERS

R20-6-2001. Reserved

R20-6-2002. Fees; Examination Costs

A. A corporation applying for a license to do business as a captive insurer, as defined in A.R.S. § 20-1098(4), shall pay a nonrefundable fee of $1,000.00 to the Department for issuance of the license. The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.

B. A captive insurer shall pay a nonrefundable annual renewal fee of $5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.01(G).

C. In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination conducted by the Director, in accordance with A.R.S. § 20-1098.06.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2).

ARTICLE 21. CUSTOMER INFORMATION SECURITY PROGRAM

Article 21, consisting of R20-6-2101 through R20-6-2104, made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2101. Definitions

The following definitions apply in this Article:

1. "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information. Consumer can include a prospective applicant, policyholder, certificateholder, insured, or claimant.
2. "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are used primarily for personal, family, or household purposes.
3. "Customer information" means nonpublic personal information and privileged information about a customer whether in paper, electronic, or other form, that is maintained by or on behalf of an insurance institution, insurance producer, or insurance support organization.
4. "Customer information systems" means the electronic, or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.
5. "Insurance institution" has the meaning prescribed in A.R.S. § 20-2102(10).
6. "Insurance producer" means a person required to be licensed under A.R.S. Title 20, Chapter 2, Article 3 to sell, solicit, or negotiate insurance and includes a managing general agent as defined in A.R.S. § 20-311.
7. "Insurance support organization" has the meaning prescribed in A.R.S. § 20-2102(13).
8. "Licensee" means an insurance institution, insurance producer, or insurance support organization, but does not include a purchasing group or an unauthorized insurer in regard to the excess line business conducted under Title 20, Chapter 2, Article 5.
9. "Personal information" has the meaning prescribed in A.R.S. § 20-2102(19).
10. "Privileged information" has the meaning prescribed in A.R.S. § 20-2102(22).
11. "Service provider" means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to a licensee.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2102. Customer Information Security Program

A licensee shall implement a comprehensive written customer information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2103. Objectives of Customer Information Security Program

A licensee's customer information security program shall be designed to:

1. Ensure the security and confidentiality of customer information;
2. Protect against any anticipated threats or hazards to the security or integrity of the information; and
3. Protect against unauthorized access to or use of the information.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2104. Guidelines for Methods of Development and Implementation

A licensee may implement the requirements of R20-6-2102 and R20-6-2103 by the actions and procedures prescribed in this Section, which are non-exclusive illustrations:

1. A licensee may assess risk by:
   a. Identifying reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;
   b. Assessing the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and
   c. Assessing the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks.
2. A licensee may manage and control risk by:
   a. Designing its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;
   b. Training staff to implement the licensee's information security program; and
   c. Regularly testing or otherwise regularly monitoring the key controls, systems and procedures of the information security program. The licensee shall determine the frequency and nature of these tests or other monitoring practices by the licensee's risk assessment.

3. A licensee may oversee service provider arrangements by:
   a. Exercising appropriate due diligence in selecting its service providers; and
   b. Requiring its service providers to implement measures designed to meet the objectives of this Article, and, where indicated by the licensee's risk assessment, taking appropriate steps to confirm that its service providers have satisfied these obligations.
4. A licensee may monitor, evaluate, and adjust, as appropriate, its information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to customer information systems.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).