20 A.A.C. 6 Supp. 19-4

Arizona Administrative CODE

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This Chapter contains rule Sections that were filed to be codified in the *Arizona Administrative Code* between the dates of October 1, 2019 through December 31, 2019

Title 20

Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

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The release of this Chapter in Supp. 19-4 replaces Supp. 19-3, 1-136 pages

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. "'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into titles. Titles are divided into chapters. A chapter includes state agency rules. Rules in chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each chapter.
First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31
For example, the first supplement for the first quarter of 2019 is cited as Supp. 19-1.

Please note: The Office publishes by chapter, not by individual rule section. Therefore there might be only a few sections codified in each chapter released in a supplement. Historical notes at the end of a section provide an effective date and information when a rule was last updated.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate chapters of the *Administrative Code* in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each *Code* chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a chapter can be found at the Secretary of State's website, under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a chapter provide information about rulemaking sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR

At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

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Rhonda Paschal, managing rules editor, assisted with the editing of this chapter.

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Administrative Rules Division
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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, 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, R4-1 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, R4-201 through R4-14-218,4-14-801 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 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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CHAPTER 6. DEPARTMENT OF INSURANCE

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. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-105. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

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. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-108. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-109. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-110. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-111. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-111 recodified from R4-14-111 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-112. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-112 recodified from R4-14-112 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-113. Expired

Historical Note
Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

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. Petition for Rulemaking Action

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). Section heading corrected at Department Request, Office File No. M11-401, filed October 27, 2011 (Supp. 11-3).

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of Health

A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:
1. "Advertisement" means materials and information used by an insurer to generate insurance business.
   a. Advertisement includes the following information:
      i. Printed and published material, audio visual material, or other forms of electronic communication that an insurer uses or displays in direct mail, newspapers, magazines, radio, television, billboards, Internet web sites, and similar media to inform the public about the insurer or its products;
      ii. Descriptive literature and sales aids an insurer issues or releases for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;
      iii. Prepared sales talks and presentations and material for use by an insurer or prepared by an insurer for use by authorized producers; and
      iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
   b. "Advertisement" does not include the following:
      i. Material used solely for training and educating an insurer's employees or producers;
      ii. Material used in-house by insurers;
      iii. Communications within an insurer's own organization not intended for dissemination to the public;
      iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
      v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
      vi. Court-approved material ordered by a court to be disseminated to policyholders;
      vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
      viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
      ix. A general announcement by the sponsor that endorses the program;
      x. Health and wellness material with general health and wellness information; or
      xi. Press releases and news releases not intended to generate business.
2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.
3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
5. "Health insurance" means:
   a. Disability insurance;
   b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;

c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.

6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
9. "Person" has the meaning in A.R.S. § 20-105.
10. "Policy" means any plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement that provides disability benefits, health insurance, medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits in the form of a cash indemnity, reimbursement, or service.
11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
    a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
    b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
    c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
    d. Is directly or indirectly compensated for making the testimonial or endorsement.

B. Scope.
1. This Section applies to all advertisements for health insurance.
2. This Section applies to the conduct of insurers, producers, and third-party administrators.

C. General requirements. Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.
1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.
3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not exaggerate any benefit through the use of phrases such as "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.
4. If a policy covers only one disease or a list of specified diseases, any advertisement for the policy shall not imply coverage beyond the specified diseases.
5. If a policy pays varying amounts for the same loss occurring under different conditions or pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall disclose the limited conditions.
6. If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses, the advertisement shall also include the maximum daily benefit and the maximum time limit for which those expenses are covered.
7. An advertisement that refers to any dollar amount, period of time for which a benefit is payable, cost of policy, or specific policy benefit or the loss for which a benefit is payable shall also disclose any related exclusions, reductions, and limitations without which the advertisement would have the capacity and tendency to mislead or deceive.
8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.
9. An advertisement shall disclose any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.
10. If a policy has an exclusion, reduction, or limitation applicable to a preexisting condition, an advertisement shall not 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 and shall not use the phrase "no medical examination required" or other similar phrase.
11. If an advertisement refers to renewability, cancellation, or termination of a policy, or states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that does not minimize or obscure the qualifying conditions.
12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).
13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.
14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.
15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.

D. Method of disclosure of required information. If an insurer is required by law to disclose particular information, the information shall be conspicuous and in close proximity to the statements to which the information relates, or under a prominent caption so that the required disclosure is not minimized, obscured, presented in an ambiguous fashion, or intermingled with the content of the advertisement.

E. Testimonials.
1. Testimonials used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. If an insurer uses a testimonial, the insurer adopts the statements in the testimonial as the insurer's own statements. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.

F. Statistics. An advertisement with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall accurately reflect all of the relevant facts specific to the advertised policy or insurer. An advertisement shall not state or imply that statistics are derived from the policy being advertised unless that is true. The insurer shall identify in the advertisement the source of any statistics used.

G. Inspection of policy. An offer in an advertisement of free inspection of a policy or offer of a premium refund does not cure misleading or deceptive statements in the advertisement.

H. Identification of plan or number of policies.
1. If an advertisement offers a choice in the amount of benefits the advertisement shall disclose that the amount of benefits depends on the policy selected and that the premium will vary with the amount of the benefits.
2. If an advertisement refers to benefits contained in more than one policy, other than a group master policy, the advertisement shall disclose that the benefits are provided only if multiple policies are purchased.

I. Disparaging comparisons and statements. An advertisement shall not make unfair, incomplete, or unsubstantiated comparisons of other insurers' policies or benefits or falsely disparage other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.

J. Jurisdictional limits. If an insurer has an advertisement that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement 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 language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."

K. Identity of insurer. The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device that may mislead or deceive the public as to the insurer's identity.

L. Group insurance. An advertisement shall not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.

M. Government approval. An advertisement shall not state or imply any of the following:
1. That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer;
2. That a governmental agency or regulator has examined an insurer's financial condition and found it satisfactory. This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.

N. Endorsements. An advertisement may state that an individual, group, society, association, or other organization has approved or endorsed the insurer or its policy if the organization or group has done so in writing and if any proprietary relationship between the organization and the insurer is disclosed.

O. Claims handling. An advertisement shall not contain false statements about the time within which claims are paid or statements that imply that claim settlements will be liberal or generous beyond the terms of the policy.

P. Statements about the insurer. An advertisement shall not contain false or misleading statements about an insurer's assets, corporate structure, financial standing, length of time in business, or relative position in the insurance business.

Historical Note

Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.01. Insurer Advertising Responsibility and Records

A. An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.

B. An insurer shall maintain, at its home or principal office, the following:
1. Advertisements disseminated by the insurer in Arizona or any other state, including:
   a. Each printed, published, recorded, or prepared advertisement of individual policies; and
   b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and

3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.

C. An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

Historical Note
New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

A. An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.

B. The transmittal form shall include the following information:
1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
2. A contact person at the insurer with whom the Department can communicate about the advertisement;
3. Description of the type of advertisement being filed;
4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
5. Description of product being advertised;
6. Form number and name for the advertised product;
7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
8. The dated signature of the insurer's officer.

Historical Note
New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

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

A. The definitions in R20-6-201(A) and the following definition apply in this Section:
"Life insurance" means a life insurance contract, including all benefits payable under the policy.

B. Applicability
1. This Section applies to:
   a. All persons subject to regulation under A.R.S. Title 20; and
   b. Advertising, promotion, solicitation, negotiation, and sale of life insurance policies, regardless of the form of dissemination.
2. This Section does not apply to group insurance, franchise insurance, or to annuities without life contingencies.

C. General provisions. A life insurance advertisement shall not mislead the public by:
1. Omitting information that fairly describes the subject matter as a life insurance policy and the benefits available under the policy;
2. Placing undue emphasis on facts that, even if true, are not relevant to the sale of life insurance; or
3. Placing undue emphasis on features of incidental or secondary importance to the life insurance aspects of the policy.

D. The Department deems the following acts misleading and deceptive:
1. Using any statement, including phrases such as "investment," "investment plan," "founders plan," "charter plan," "expansion plan," "profit," "profits," or "profit sharing," in a context or under circumstances or conditions that may mislead a purchaser or prospective purchaser to believe that the insurer is selling something other than a life insurance policy or will provide some benefit not included in the policy, or not available to other persons of the same class and equal expectation of life;
2. Using any phrase as the name or title of a life insurance policy if the phrase does not include the words "life insurance," unless other language in the same document expressly provides that the contract is a life insurance policy;
3. 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 that would reasonably be understood as attempting to interest a prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy;
4. Making any statement that reasonably tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by purchasing the policy, unless the statement is made with reference to policies of domestic life insurers engaged in a program allowed under A.R.S. § 20-453;
5. Providing a policyholder with a premium receipt book, policy jacket, return envelope, or other printed or electronic material referring to the insurer's "investment department," "insured investment department," or similar terminology in a manner implying that the policy is sold, issued, or serviced by the insurer's investment department;
6. Making any statement that 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 the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment;
7. Stating or implying that only a limited number of persons or limited class of persons may buy a particular kind of policy, unless the limitation is related to recognized underwriting practices or specifically stated in the policy or rider;
8. Describing premium payments in language that states the payment is a "deposit," unless:
   a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or
   b. The term is used with the word "premium" in a manner as to clearly indicate the true character of the payment;
9. Providing any illustration or projection of future dividends that:
   a. Is not based on the company's actual scale for payment of current dividends, and
   b. Does not clearly indicate that the dividends are not guarantees;
10. Using the words "dividends," "cash dividends," "surplus," or similar phrases in a manner that states or implies that the payment of dividends is guaranteed or certain to occur;
11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer's earnings;
12. 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 also explains:
   a. The benefits or coverage that would be provided at the future time, and
   b. The conditions under which the receipt of benefits without further payment of premiums would occur;
13. Describing a life insurance policy or premium payments in terms of "units of participation," unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as applicable.
14. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;
15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without explaining the non-forfeiture benefits;
16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language that:
   a. States the nature of the dollar amount,
   b. Prohibits including the use of dollar amounts not related to guaranteed values and properly projected dividend figures, and
   c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.
17. Stating that a policy provides features not found in any other insurance policy, unless the insurer can demonstrate that other policies do not have the same feature;
18. Making any statement or implication about an insurance policy that cannot be verified by reference to the policy contract, a sample of the policy being described, or the company's officially published rate book and dividend illustrations;
19. Stating that life insurance is "loss proof" or "depression proof," except that an insurer may make statements that life insurance benefits, other than dividends, are guaranteed by the company regardless of economic conditions;
20. Making any statement that a company makes a profit as a result of policy lapses or surrenders;
21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience for the company issuing the advertising; and
22. Conduct or statements designed to mislead a prospective applicant or purchaser.

Historical Note

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-203. Form Filings; Translations

A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material contains communication in a language other than English.

B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.

C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.

D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

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). New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-204. Expired

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). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 136, effective December 15, 2016 (Supp. 16-4).

R20-6-205. Local or Regional Retaliatory Tax Information

A. Definitions.
1. "Addition to the rate of tax" means the tax rate determined under subsection (D) 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 that impose 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 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.
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 producers by any:
   a. City, county, or other political subdivision of a foreign country or other state; or
   b. 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, excluding Arizona.
13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.

B. Scope. This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.

C. Data to be reported by domestic insurers. As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports 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.

D. 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 other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.

E. 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 under subsection (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

F. 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.

G. Contesting computation. A foreign or alien insurer subject to this Section 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.

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). Section R20-6-205 renumbered from R20-6-206 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-206. Expired

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). Former R20-6-206 renumbered to R20-6-205; new R20-6-206 renumbered from R20-6-207 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-207. Gender Discrimination

A. The following definitions apply to this Section:
1. "Applicant" means a person who is applying for a policy.
2. "Policy" means an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including a rider or endorsement offered by an insurer.
3. "Insurer" means any company that issues a policy.

B. Applicability and scope. This Section applies to any policy or certificate delivered or issued for delivery in this state.

C. Availability requirements.
1. An insurer shall not deny availability of any insurance policy on the basis of the gender or marital status of the insured or prospective insured.
2. An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage on the basis of an applicant's or insured's gender or marital status, 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 A.R.S. Title 20.

3. An insurer may consider marital status to determine whether a person is eligible for dependent coverage or benefits.

D. Prohibited practices. The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited.

1. Denying coverage to a person of one gender who is self-employed, employed part-time, or employed by relatives, if coverage is offered to a person of the opposite gender who is similarly employed;
2. Denying a policy rider to a person of one gender if the rider is available to a person of the opposite gender;
3. Denying maternity benefits to an applicant or insured who buys a policy for individual coverage if the insurer offers comparable family coverage policies with maternity benefits;
4. Denying, under group policies, dependent coverage to an employee of one gender if dependent coverage is available to an employee of the opposite gender;
5. Denying a disability income policy to an employed person of one gender if a policy is offered to a person of the opposite gender who is similarly employed;
6. Treating complications of pregnancy differently from any other illness or sickness covered under a policy;
7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one gender;
8. Offering lower maximum monthly benefits to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
9. Offering more restrictive benefit periods or more restrictive definitions of disability to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
10. Establishing different conditions for a policyholder of one gender to exercise benefit options contained in the policy than for a person of the opposite gender;
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 the limitation is for the purpose of defining persons eligible for dependent's benefits; and
12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contract, the amount of benefits payable, or any term, condition or type of coverage on account of gender or marital status in all lines of insurance.

Historical Note

Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1). Former R20-6-207 renumbered to R20-6-206; new R20-6-207 renumbered from R20-6-209 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-208. Group Coverage Discontinuance and Replacement

A. Definitions. The following definitions apply in this Section:

1. "Group insurance" means an insurance benefit that meets all the following conditions:
   a. 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;
   b. 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;
   c. Coverage is paid for by bulk payment of premiums to the insurer; and
   d. An employer, union, or association sponsors the plan.
2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:
   a. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
   b. Coverage issued as a supplement to liability insurance;
   c. Liability insurance, including general liability insurance and automobile liability insurance;
   d. Workers' compensation or similar insurance;
   e. Automobile medical payment insurance;
   f. Credit-only insurance;
   g. Coverage for onsite medical clinics; and
   h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.
   i. 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 the coverage:
      i. Limited-scope dental or vision benefits;
      ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;
      iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.
   j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:
      i. Coverage only for a specified disease or illness, or
      ii. Hospital indemnity or other fixed indemnity insurance.
   k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:
      i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;
      ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or
      iii. Similar supplemental coverage provided to coverage under a group health plan.
3. "Health status-related factor" means any of the following:
   a. Health status;

b. Medical condition, including a physical or mental illness;
c. Claims experience;
d. Receipt of health care;
e. Medical history;
f. Genetic information;
g. Evidence of insurability, including conditions arising out of acts of domestic violence; or
h. Disability.

4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.

B. This Section applies to all group insurance issued by an insurer.

C. Effective date of discontinuance for non-payment of premium.

1. If a group insurance policy provides for automatic discontinuance of the policy after a premium remains unpaid through the grace period allowed for payment, the insurer is liable for valid claims for covered losses incurred before the end of the grace period.
2. If the insurer's actions after the end of the grace period indicate that the insurer considers the group insurance policy as continuing in force beyond the end of the grace period the insurer is liable for valid claims for losses beginning before the effective date of written notice of discontinuance to the policyholder or other entity responsible for paying premiums.
   a. The following actions indicate that the insurer considers the policy in force:
      i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or
      ii. Continued enrollment of employees or dependents.
   b. The following actions shall not indicate that the insurer considers that policy in force:
      i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or
      ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.
3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.

D. Requirements for notice of discontinuance.

1. An insurer's notice of discontinuance shall include a request to the group policyholder to notify covered employees of the date when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the insurer is not liable for claims for losses incurred after the date of discontinuance. If the plan involves employee contributions, the notice of discontinuance shall also advise that if the policyholder continues to collect employee contributions beyond the date of discontinuance, the policyholder is solely liable for benefits for the period which contributions were collected.
2. The insurer shall also provide the policyholder with a supply of notice forms that the policyholder can distribute to the covered employees. The notice forms shall explain the discontinuance and the effective date, and advise employees to refer to their certificates or contracts to determine their rights on discontinuance.

E. Extension of benefits.

1. A group policy shall provide a reasonable provision for extension of benefits for an employee or dependent who is totally disabled on the date of discontinuance as follows:
   a. For a group life plan with a disability benefit extension of any type such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not terminate the benefit extension.
   b. For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall not effect benefits payable for that disability or hospital confinement.
   c. A hospital or medical expense coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision. A provision is reasonable if:
      i. It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverage; or
      ii. Under other types of hospital or medical expense coverage, it 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 that occurred while coverage was in force, such as an accident.
2. An insurer shall ensure that the policy and group insurance certificates includes a description of the extension of benefits or accrued liability provision.
3. An insurer shall ensure that benefits payable during a period of extension or accrued liability are subject to the policy's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.

F. Continuance of coverage in situations involving replacement of one plan by another.

1. When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance.
2. The succeeding insurer shall cover each individual who:
   a. Was eligible for coverage under the prior plan on the date of discontinuance, and
   b. Is eligible for coverage according to the succeeding insurer's plan of benefits with respect to a class of individuals eligible for coverage.
3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:
   a. Not have any non-confinement rules; and

b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.

4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.
5. A succeeding insurer shall cover each individual not covered under the succeeding insurer's plan of benefits under subsection (F)(2) according to subsections (a) and (b) if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and is a member of a class of individuals eligible for coverage under the succeeding insurer's plan. Any reference in subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual's status immediately before the effective date of coverage for the succeeding insurer.
   a. The minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan reduced by any benefits payable by the prior plan.
   b. The succeeding insurer shall provide coverage until at least the earliest of the following dates:
      i. The date the individual becomes eligible under the succeeding insurer's plan as described in subsection (F)(2);
      ii. The date the individual's coverage would terminate according to the succeeding insurer's plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be eligible dependent; or
      iii. For an individual who was totally disabled, and covered by a type of coverage for which subsection (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability that is required of the prior insurer under subsection (E), or if the prior insurer's policy is not subject to subsection (E), would have been required of the insurer had its policy been subject to subsection (E) at the time the prior plan was discontinued and replaced by the succeeding insurer's plan;
   c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan, reduced by any benefits paid by the prior plan.
   d. If the succeeding insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding insurer's plan according to subsection (F) during the period the limitation applies under the new plan shall be the lesser of:
      i. The benefits of the new plan determined without application of the preexisting conditions limitation, or
      ii. The benefits of the prior plan.
   e. The succeeding insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. For deductibles or coinsurance amounts applicable to out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior plan during the 90 days before the effective date of the succeeding insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding insurer's plan and are subject to similar deductible or coinsurance provisions.
   f. If the succeeding insurer is required under this Section to make a determination about the benefits in the prior plan, the succeeding insurer may ask the prior plan to provide a statement of the benefits available or other pertinent information sufficient to permit the succeeding insurer to verify the benefit determination. For the purposes of this Section, all definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination. The benefit determination is made as if the succeeding insurer had not replaced coverage.

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). Section R20-6-208 renumbered from R20-6-210 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-209. Life Insurance Solicitation

A. Scope.
1. This Section applies to any solicitation, negotiation, or procurement of life insurance occurring in Arizona. This Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
2. Unless otherwise specifically included, the Section does not apply to:
   a. Annuities,
   b. Credit life insurance,
   c. Group life insurance,
   d. Life insurance policies issued in connection with a pension and welfare plan as defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or
   e. Variable life insurance under which the death benefits and cash values vary according to unit values of investments held in a separate account.

B. In this Section, the following apply:
1. "Buyer's Guide" means a document that contains the language in the Appendix to this Section or language approved by the Director.
2. "Cash dividend" means the current illustrated dividend that can be applied toward payment of the gross premium.
3. "Equivalent Level Annual Dividend" is calculated as follows:
   a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the 10th and 20th policy years;
   b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in subsection (a) over the periods stipulated in

subsection (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 in subsection (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" means the amount of benefit of a policy or term life insurance rider 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 10th and 20th policy years, respectively.
   b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (a) over the periods stipulated in subsection (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" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.
6. "Life Insurance Surrender Cost Index" means the cost index that is calculated as follows:
   a. Determine the guaranteed cash surrender value, if any, available at the end of the 10th and 20th policy years.
   b. For policies participating in dividends, 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 subsection (a).
   c. Divide the result in subsection (b) (subsection (a) 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 subsection (b) or subsection (a) for guaranteed cost policies, over the periods stipulated in subsection (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
   d. 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 subsection (a) and dividing the result by the respective factors stated in subsection (c). This amount is the annual premium payable for a level premium plan.
   e. Subtract the result of subsection (c) from subsection (d).
   f. Divide the result of subsection (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
7. 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.
8. "Policy Summary" means a written statement describing elements of the policy, including:
   a. The following prominently placed title: Statement of Policy Cost and Benefit Information.
   b. The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed to receive responses to inquiries regarding the Policy Summary.
   c. The full name and home office or administrative office address of the company by which the life insurance policy is to be or has been written.
   d. The generic name of the basic policy and each rider.
   e. For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier, the following amounts, where applicable:
      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 except for suicide, or other specifically enumerated exclusions 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; and
      vi. Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values in subsection (iv).
   f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall include the maximum annual percentage rate.
   g. Life Insurance Cost Indexes for 10 and 20 years but not beyond the premium-paying period. Separate indexes shall be displayed for the basic policy and for each optional term life insurance rider. The indexes need not be included for optional riders that 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. If the Policy Summary includes dividends, a statement that dividends are based on the insurer's current dividend scale and are not guaranteed and 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 shall consist of a separate document. All information required to be disclosed shall not be minimized or obscure. Any amounts that remain level for two or more years of the policy may be represented by a single number that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection (8)(e) 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.

C. Disclosure requirements.

1. The insurer shall provide to all prospective purchasers, a Buyer's Guide and a Policy Summary before 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 an unconditional refund offer, in which case the Buyer's Guide and Policy Summary shall be delivered with the policy or before delivery of the policy.
2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
3. If the Equivalent Level Death Benefit of a policy does not exceed $5,000, the requirement for providing a Policy Summary is satisfied by delivery of a written statement containing the information described in subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).

D. General rules.

1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a copy of each form the insurer authorized for use.
2. A producer shall inform a prospective purchaser, before commencing a life insurance sales presentation, that the producer is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurance company that the producer is representing. If an insurance producer is not involved in the sale, the insurer shall inform the prospective purchaser of the insurance company's full name.
3. An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial counseling to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is true.
4. If an insurer or producer refers to policy dividends, the reference shall include a statement that dividends are not guaranteed.
5. An insurer shall not use a system or presentation that does not recognize the time value of money through the use of appropriate interest adjustments for comparing the cost of two or more life insurance policies unless the system or presentation is used to demonstrate the cash flow pattern of a policy and the 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. In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity.
7. An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
8. An insurer shall include with a Life Insurance Cost Index that reflects dividends or an Equivalent Level Annual Dividend a statement that it is based on the company's current dividend scale and is not guaranteed.
9. If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.

E. An insurer's failure to provide or deliver a Buyer's Guide or a Policy Summary as provided in subsection (C) constitutes an omission that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

Appendix. Life Insurance Buyers Guide

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 that 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 that are described in this guide. A good life insurance producer 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 that 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 producer 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 producer 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 that 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 producers 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 producer. 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 producer 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 that 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 producer 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 producer 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 June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1). Former R20-6-209 renumbered to R20-6-207; new R20-6-209 renumbered from R20-6-211 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

A. Definitions. The following definitions apply in this Section:
1. "Readable insurance policy" means a policy that can be read and reasonably understood by a person without special knowledge or training.
2. "Policy" means a contract or agreement for insurance, or an insurance certificate regardless of the name used, and includes all clauses, endorsements, and papers attached or incorporated.

B. Scope. This Section applies to private passenger motor vehicle policies, homeowner policies, personal line dwelling policies, for four family units or less, and mobile homeowner policies delivered or issued for delivery in Arizona.

C. Compliance.
1. An insurer shall 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. An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale.
3. An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.

D. Readability guidelines.
1. General organization of text.
   a. A policy shall be divided into logically arranged sections for ease of locating content.
   b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
   c. General policy provisions applying to all or several like coverages shall be located in a common area.
   d. The policy shall not contain non-essential provisions.
   e. Defined words and terms shall be placed in a separate section at the beginning of the policy.
2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
   a. Type size shall be at least eight point.
   b. The font shall be block print rather than script, and legible.
   c. Captions and headings shall be distinguishable from the general text.
   d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
   e. Defined words and terms shall be distinguishable from the general text.

3. Language usage. The insurer shall ensure that each policy:
   a. Is written in everyday, conversational language;
   b. Uses short, simple sentences and words in common usage;
   c. Uses an easy-to-read style, personal pronouns, and present tense active verbs.

Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1). Former R20-6-210 renumbered to R20-6-208; new R20-6-210 renumbered from R20-6-212 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness

A. Definitions. The following definitions apply in this Section:
1. "Policy" means a contract or agreement for or effecting insurance, or a certificate of insurance, regardless of the name used, and includes all clauses, riders, endorsements, and attached papers.
2. "Person" has the same meaning prescribed in A.R.S. § 20-105.

B. Scope. This Section applies to all policies delivered or issued for delivery in this state.

C. Prohibition. An insurer shall not engage in the following prohibited acts or practices that constitute unfair discrimination between individuals of the same class:
1. Refusal to insure or refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness; or
2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

D. In this subsection, "refusal to insure" includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed if the insured loses eyesight. An insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness if the insured was blind or partially blind when the policy was issued.

E. For all other conditions, including the underlying cause of the blindness or partial blindness, a person who is blind or partially blind is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person.

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). Former R20-6-211 renumbered to R20-6-209; new R20-6-211 renumbered from R20-6-213 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at 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:
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 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). Former R20-6-212 renumbered to R20-6-210; new R20-6-212 renumbered from R20-6-215 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212.01. Forms for Buyer's Guide for Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at 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:

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

Section R20-6-212.01 renumbered from R20-6-215.01 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-213. Life and Disability Insurance Policy Language Simplification

A. Definitions. The following definitions apply in this Section:
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 under a group insurance policy delivered or issued for delivery in this state.

B. Applicability.

1. This Section and R20-6-212 apply to all life and disability insurance policies delivered or issued for delivery in this state by any company but do not apply to:
   a. Any policy that 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 under a group policy delivered or issued for delivery in this state; or
   c. Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
2. Except as provided in R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

C. Minimum policy language simplification standards.
1. Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director 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 subsection (3);
   b. It is printed, except for specification pages, schedules, and tables, in no less than 10 point type, one point leaded;
   c. The style, arrangement and overall appearance of the policy do not give undue prominence to any portion of the text of the policy or to any endorsements or riders; and
   d. 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, contains a table of contents or an index of the principal sections of the policy.
2. An insurer shall measure a Flesch reading ease test score as follows:
   a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page instead of the entire form. The insurer shall separate the samples by at least 20 printed lines.
   b. The insurer shall count the number of words and sentences in the text, then divide the total number of words by the total number of sentences, then multiply that figure by a factor of 1.015.
   c. The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
   d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
   e. For subsections (b), (c), and (d), the insurer shall use the following procedures:
      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. If 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. Policy language that is drafted to conform to the requirements of a federal law, regulation, or agency interpretation, policy language required by a collectively bargained agreement, medical terminology, words defined in the policy, and policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this subsection and certifies, in writing, that the language or terminology is entitled to be excepted by this subsection.
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 the filing 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 under subsection (G) of this Section. 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.

D. The Director may authorize a lower score than the Flesch reading ease score required in subsection (C)(1)(a) if a lower score:
1. Provides 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 drafted to conform to the requirements of any state statute, rule, or agency interpretation of law.

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). Former R20-6-213 renumbered to R20-6-211; new R20-6-213 renumbered from R20-6-216 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Corrected error in R20-6-213(D) that referenced subsection (E)(1)(a), which was relabeled as (C)(1)(a) in Supp. 07-2 (Supp. 08-1).

R20-6-214. Coordination of Benefits

A. Applicability.
1. This Section applies to all:
   a. Group disability insurance policies;
   b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
   c. Group disability policies of benefit insurers; and

d. Group-type contracts that contain a coordination of benefits provision, 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. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.

2. This Section does not apply to:
   a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
   b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of $30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type benefits, instead of the reimbursement type benefits at the time of claim; or
   c. School accident type coverages, written on a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:
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 is deemed to be both an allowable expense and a benefit paid.
   b. A plan that 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 that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.
4. "School accident-type coverage" means coverage of 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 that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
   a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
   b. The 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 subsection 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 the following 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 subsection (c), 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 that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that 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 subsection does apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that 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. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:
1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The payment shall be the limit of the complying plan's liability, except as provided in subsection (4).
3. 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 benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.

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). Section R20-

6-214 renumbered from R20-6-217 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215. Renumbered

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). Former R20-6-215 renumbered to R20-6-212 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215.01. Renumbered

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215.01 renumbered to R20-6-212.01 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-216. Renumbered

Historical Note

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1). Former R20-6-216 renumbered to R20-6-213 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-217. Renumbered

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). Former R20-6-217 renumbered to R20-6-214 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

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. Termination of Certificate of Authority and Release of Deposit

A. Domestic Insurers. To request termination of a certificate of authority and, if applicable, release of statutory deposit, a domestic insurer shall file all of the following with the director:

1. A written request for termination of certificate of authority and release of deposit;
2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
4. A plan of extinguishment for its outstanding liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no outstanding liabilities to policyholders or claimants under subsection (C);
5. A certified copy of the insurer's Board of Directors resolution or other documentation of the insurer's official action taken according to the insurer's statutorily required organizational documents approving the insurer's:
   a. Withdrawal from the insurance business,
   b. Dissolution of the insurer,
   c. Merger with an insurer authorized in Arizona to transact the insurer's previously written and active lines of business of the insurer requesting termination, or
   d. Transfer of domicile to another state or country.
6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication, or other documentation that the insurer intends to file with the Arizona Corporation Commission after issuance of the Director's order as provided in subsection (D)(2);
7. If requested by the director, a written agreement that guarantees payment of substantially all liabilities of the domestic insurer, other than obligations extinguished under subsection (C).

B. Foreign and Alien Insurers. To request termination of its certificate of authority and, if applicable, release of its deposit, a foreign or alien insurer shall file all of the following with the director:

1. A written request for termination of certificate of authority and release of deposit;
2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
4. A plan of extinguishment for its Arizona liabilities that satisfies the requirements of subsection (C) or a sworn

affidavit stating that the insurer has no Arizona liabilities under subsection (C);

5. A copy of an order issued by the insurance director or other appropriate regulatory authority in the insurer's state or country of domicile that approves or authorizes either the insurer's:
   a. Withdrawal from the insurance business,
   b. Dissolution of the insurer,
   c. Merger (approval of the merger from the states of domicile of the insurers), or
   d. Transfer of domicile, if applicable.
6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication or other required documentation that the insurer filed in its state of domicile; and
7. If requested by the director, a written agreement that guarantees payment of substantially all Arizona liabilities of the insurer, other than obligations extinguished under subsection (C).

C. Insurer's Plan for Extinguishment of Liabilities.

1. To extinguish substantially all liabilities under subsection (A)(4) or subsection (B)(4) as applicable, an insurer may:
   a. Reinsure the insurer's business in force with another insurer by entering into an agreement of bulk reinsurance that shall be effective when filed with and approved in writing by the director.
      i. The agreement shall provide for assumption of all policyholder claims by the reinsurer including claims incurred but unreported as of the effective date of the agreement.
      ii. The agreement may include recapture provisions exercisable by the insurer in the event the termination of its certificate of authority is not completed.
      iii. Unless the director otherwise approves, the agreement shall provide that the reinsurer be licensed in Arizona for the particular lines of business reinsured.
   b. Merge with another insurer that:
      i. Assumes the liabilities of the non-surviving insurer; and
      ii. Is authorized in Arizona for the previously written and active lines of business assumed, unless otherwise approved by the director.
   c. Use its deposit, any additional security deposit or both to secure payment of former policyholder, policyholder, or claimant liabilities that are not reinsured or otherwise secured.
2. For purposes of this Section, "substantially all liabilities" under Title 20 means all policyholder and claimant obligations reported by the insurer in the statement of financial condition, whether or not liquidated in amount, and shall include former policyholder claims and rights to refunds.

D. Consideration of the Request for Termination of Certificate of Authority and Release of Deposit under subsections (A) and (B).

1. If the director determines that the insurer has extinguished substantially all liabilities as required under this Section and has otherwise demonstrated compliance with this Section and A.R.S. Title 20, the director shall grant the request to terminate the certificate of authority and, if appropriate, release the insurer's deposit, provided:
   a. The insurer has no fees, taxes, assessments or filings outstanding to the Department; and
   b. The insurer is not subject of any pending investigation or examination under Title 20 by the Department.
2. The director's order shall condition the release of a domestic insurer's deposit upon receipt by the director of evidence of the official filing with the Arizona Corporation Commission of the documentation described in subsection (A)(6).
3. If the director determines that the insurer is unable to extinguish substantially all liabilities as required under this Section, or otherwise has not complied with this Section or with A.R.S. Title 20, the director shall notify the insured in writing that the request has been denied and the reasons for the denial.

E. Exclusions. This Section does not apply to:

1. An insurer's exchange and substitution of cash or eligible securities under A.R.S. § 20-586;
2. An insurer's withdrawal of excess deposits, either cash or eligible securities, under A.R.S. §§ 20-587 and 20-588(A)(2); or
3. Releases of deposits made under 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). Section R20-6-303 repealed; new Section R20-6-303 made by final rulemaking at 14 A.A.R. 3432, effective October 4, 2008 (Supp 08-3).

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. Expired

Historical Note

Adopted effective March 22, 1993 (Supp. 93-1). R20-6-308 recodified from R4-14-308 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-309. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.01. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.02. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.03. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.04. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-310. Corporate Governance

The purpose of Sections R20-6-310.01 through R20-6-310.03 is to set forth procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD) deemed necessary by the Director to carry out the provisions of Title 20, Chapter 2, Article 16 on Corporate Governance.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.01. Definitions

The definitions in A.R.S. § 20-492 and this Section apply to Sections R20-6-310.02 through R20-6-310.04.

"CGAD" means Corporate Governance Annual Disclosure.

"NAIC" means National Association of Insurance Commissioners.

"Senior Management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.02. Filing Procedures

A. Deadline to file. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by A.A.C. Title 20, Chapter 2, Article 16 shall, no later than June 1 of each calendar year, submit to the Director a CGAD that contains the information described in Section R20-6-310.03.

B. Attestation. The CGAD must include a signature of the insurer's or insurance group's CEO or corporate secretary attesting to the best of that person's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that the copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors or appropriate committee of the Board of Directors.

C. Format of the CGAD. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Director to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. Insurer or insurance group to determine level of reporting.

1. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending on how the insurer or insurance group has structured its system of corporate governance.
2. The insurer or insurance group is encouraged to make the CGAD disclosures at:
   a. The level at which the insurer's or insurance group's risk appetite is determined,
   b. The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or
   c. The level at which legal liability for failure of general corporate governance duties would be placed.
3. If the insurer or insurance group determines the level of reporting based on the criteria in subsection (D)(2), it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

E. CGAD completed at the insurance group level. Notwithstanding subsection (A) and as outlined in A.R.S. § 20-492.01, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the NAIC's Financial Analysis Handbook 2018 Annual/2019 Quarterly, pp. 771 through 774, and no future editions. In these instances, a copy of the CGAD must also be provided, upon request, to the chief regulatory official of any state in which the insurance group has a domestic insurer.

F. Reference to other existing documents. An insurer or insurance group may comply with this Section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in R20-6-310.03. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the Director.

G. Subsequent filings of the CGAD. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made to the previously filed CGAD. The filing shall also state if no changes are made to the information or activities previously reported by the insurer or insurance group.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.03. Contents of CGAD

A. Inclusion of attachments. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

B. Board. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

1. The Board and its various committees ultimately responsible for overseeing the insurer or insurance group and the level or levels at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and
2. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of the Chief Executive Officer (CEO) and Chairman of the Board within the organization.

C. Senior Governing Entity. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and its significant committees, including a discussion of the following factors:

1. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.
2. How an appropriate amount of independence is maintained on the Board and its significant committees.
3. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.
4. How the insurer or insurance group identifies, nominates and elects members of the Board and its committees. The discussion should include, for example:
   a. Whether a nomination committee is in place to identify and select individuals for consideration.
   b. Whether term limits are placed on directors.
   c. How the election and re-election processes function.
   d. Whether a Board diversity policy is in place and if so, how it functions.
5. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

D. Senior Management. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

1. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:
   a. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.
   b. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.
2. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:
   a. Compliance with laws, rules, and regulations; and
   b. Proactive reporting of any illegal or unethical behavior.
3. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Director to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk-taking. Elements to be discussed may include, for example:
   a. The Board's role in overseeing management compensation programs and practices.
   b. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;
   c. How compensation programs are related to both company and individual performance over time;
   d. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;
   e. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;
   f. Any other factors relevant to understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.
4. The insurer's or insurance group's plans for CEO and Senior Management succession.

E. Oversight. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:
1. How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;
2. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps the Senior Management is taking to monitor and manage those risks;
3. How reporting responsibilities are organized for each critical risk area. The description should allow the Director to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:
   a. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report submitted pursuant to A.R.S. § 20-491.03);
   b. Actuarial function;
   c. Investment decision-making processes;
   d. Reinsurance decision-making processes;
   e. Business strategy/finance decision-making processes;
   f. Compliance function;
   g. Financial reporting/internal auditing; and
   h. Market conduct decision-making processes.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.04. Severability Clause

If any provision of this Section, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this Section which can be given effect without the invalid provision or application, and to that end the provisions of this Section are severable.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

Appendix A. Expired

Table 1. Expired

Table 2. Expired

Table 3. Expired

Table 4. Expired

Table 5. Expired

Table 6. Expired

Historical Note

Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Appendix A (including Tables 1 through 6) expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

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 Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with and available from the Department of Insurance, 100 N. 15th Ave., Suite 102, Phoenix, AZ 85007-2624 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197, 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). Section amended by final expedited rulemaking with an immediate effective date of September 16, 2019 (Supp. 19-3).

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 misrepresentation.
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 require-

ments 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 examinations 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 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. 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:

1. The service company provides a bond or mechanical reimbursement policy which covers the outstanding service contract liabilities.
2. 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.
3. Evidence satisfactory to the director that:
   a. All outstanding service contracts and liabilities have expired or been cancelled in accordance with the service contract terms,
   b. That all claims have been settled,
   c. That there is no reason to believe there are any unreported claims, and
   d. 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. Expired

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). Section expired under A.R.S. § 41-1056(J) at 24 A.A.R. 3106, effective October 9, 2018 (Supp. 18-4).

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 consideration 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 pro-

vision 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.
3. A history of the experience under existing rates, including at least the data indicated in subsection (E). 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. All additional data must be reconciled, as appropriate, to the required data. Additional data might include:
   a. Substitution of actual claim run-offs for claim reserves and liabilities,
   b. Determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums,
   c. Substitution of net level policy reserves for preliminary term policy reserves,
   d. Adjustment of premiums to an annual mode basis, or
   e. Other adjustments or schedules suited to the form and to the records of the company.
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 $700, 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 $200 or more but less than $700, subtract 5 percentage points from the numbers in the table above, or if less than $200, 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 factional 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 (G) 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)(1) and (H)(2) 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; and
   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; and
   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). Amended by final rulemaking at 24 A.A.R. 103, effective February 17, 2018 (Supp. 17-4).

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 during 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 Table

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, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care, delivered or issued for delivery in this state by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care service 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). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1002. Definitions

The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article.

A. "Benefit trigger," for purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B(b) of the Internal Revenue Code of 1968, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

B. "Exceptional increase" means only those rate increases that an insurer has filed as exceptional and that the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of insurers of similar products.
1. Except as provided in Sections R20-6-1014 and R20-6-1015, exceptional increases are subject to the same requirements as other premium rate schedule increases.
2. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase.
3. The Director may also determine whether there are any potential offsets to higher claims costs.

C. "Incidental," as used in R20-6-1014(L) and R20-6-1015(L), means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.

D. "Licensed health care professional" means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

E. "Long-term care benefit classification" means one of the following:
1. Institutional long-term care – benefits only;
2. Non-institutional long-term care – benefits only; or
3. Comprehensive long-term care benefits.

F. "Managed care plan" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, use of specific provider networks, or a combination of these methods.

G. "Personal information" has the same meaning prescribed in A.R.S. § 20-2102(19).

H. "Privileged information" has the same meaning prescribed in A.R.S. § 20-2102(22).

I. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

J. "Similar policy forms" means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1002 recodified from R4-14-1002 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1003. Policy Terms

A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
1. "Activities of daily living" means eating, toileting, transferring, bathing, dressing, or continence.
2. "Acute condition" means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.
3. "Adult day care" means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
4. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
5. "Bathing" means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
6. "Chronically ill individual" has the meaning prescribed for this term by A.R.S. § 20-1691(3) and Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.
   a. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
      i. Being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to loss of functional capacity; or
      ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
   b. The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
7. "Cognitive impairment" means a deficiency in a person's:
   a. Short or long-term memory;
   b. Orientation as to person, place, or time;
   c. Deductive or abstract reasoning; or
   d. Judgment as it relates to safety awareness.
8. "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
9. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
10. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
11. "Guaranteed renewable" means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and 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 the insurer may revise rates on a class basis.
12. "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
13. "Home health services" means the services described at A.R.S. § 36-151.
14. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
15. "Licensed health care practitioner" has the same meaning as A.R.S. § 20-1691(7).

16. "Maintenance or personal care services" has the same meaning as A.R.S. § 20-1691(10).
17. "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.
18. "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 cancel or make any change in any provision of the insurance or in the premium rate.
19. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
20. "Qualified long-term care services" has the meaning prescribed for this term under A.R.S. § 20-1691(14) and means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
21. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
22. "Transferring" means moving into or out of a bed, chair, or wheelchair.

B. Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:

1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
4. "Skilled nursing care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.
5. Service providers, including "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1003 recodified from R4-14-1003 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1004. Required Policy Provisions

A. Renewability

1. An individual long-term care insurance policy shall contain a renewability provision which shall be either "guaranteed renewable" or "noncancellable." The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall state that the coverage is guaranteed renewable or noncancellable. This requirement does not apply to a long-term care insurance policy that is part of or combined with a life insurance policy that does not contain a renewability provision and that reserves the right not to renew solely to the policyholder.
2. An insurer shall not use the terms "guaranteed renewable" and "noncancellable" in any individual long-term care insurance policy without further explanatory language according to the disclosure requirements of this Article.
3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended, in the policy.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

B. Limitations and Exclusions

1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility not prohibited by A.R.S. §§ 20-1691.03 and 20-1691.05 shall describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
3. A policy shall not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
   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 auxiliary units;
      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;

f. Services for which benefits are available under Medicare or other governmental program, except Medicaid;
g. Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
h. 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;
i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
j. In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount;

4. Subsection (B) does not prohibit exclusions and limitations by type of provider or territorial limitations. No long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:
   a. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
   b. When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
5. "State of policy issue" means the state in which the insurer issued the individual policyor certificate.

C. Extension of benefits. A long-term care insurance policy shall provide that termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this extension of benefits period to the duration of the benefit period, if any, or to payment of the maximum benefits and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.

D. Reinstatement. A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.

E. Continuation or conversion.
1. A group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
2. The policy shall include a provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, subject only to the continued timely payment of premiums when due. A group policy that restricts provision of benefits and services to, or has incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.
3. The policy shall include a 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 continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits that the Director determines to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity, and other plan elements.
5. An insurer may require an individual seeking a conversion policy to make a written application for the converted policy and pay the first premium due, if any, as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy effective on the day following the termination of coverage under the group policy. The converted policy shall be renewable annually.
6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If 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.
7. An insurer is required to provide continuation of coverage or issuance of a converted policy as provided in this subsection, unless:
   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 that:
      i. Is effective on the day following the termination of coverage;
      ii. Provides benefits identical to or benefits the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and
      iii. Has a premium calculated in a manner consistent with the requirements of subsection (E)(6).
8. Notwithstanding any other provision of this Section, a converted policy that an insurer issues to an individual

who at the time of conversion is covered by another long-term care insurance policy providing benefits on the basis of incurred expenses, may contain a provision that reduces 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. An insurer may include this provision in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in payable benefits.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
10. Notwithstanding any other provision of this Section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, is entitled to continuation of coverage under the group policy if the qualifying relationship terminates by death or dissolution of marriage.

F. 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.

G. Premium Increases.

1. An insurer shall not increase the premium charged to an insured because of:
   a. The increasing age of the insured at ages beyond 65, or
   b. The duration of coverage under the policy.
2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.

H. Electronic enrollment for group policies.

1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:
   a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
   b. The telephonic or electronic enrollment process has necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of individually identifiable and privileged information.
2. If the Director requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.

I. Minimum standards for home health and community care benefits.

1. If an insurer issues a long-term care insurance policy or certificate that provides benefits for home-health or community care, the policy or certificate shall not limit or exclude benefits by any of the following:
   a. Requiring that the insured would need skilled care in a skilled nursing facility if home health services are not provided;
   b. Requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health services are covered;
   c. Requiring that eligible services be provided by a registered nurse or licensed practical nurse;
   d. 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 licensure or certification;
   e. Requiring that the insured or claimant have an acute condition before home health services are covered;
   f. Limiting benefits to services provided by Medicare-certified agencies or providers;
   g. Excluding coverage for personal care services provided by a home health aide;
   h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
   i. Excluding coverage for adult day care services.
2. If a long-term care insurance policy provides benefits for home health or community care services, it shall provide home health or community care coverage that equals a dollar amount equivalent to at least one-half of one year's missing home benefit coverage available at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.
3. An insurer may apply home health care coverage to non-home health care benefits in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

J. Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1004 recodified from R4-14-1004 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1005. Unintentional Lapse

A. An insured may designate in writing at least one person to receive notice of lapse or termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.

B. An insurer shall not issue an individual long-term care insurance policy or certificate until the applicant has provided either a written designation of at least one person, in addition

to the applicant, who shall receive notice of lapse or termination of the policy or certificate for nonpayment of premium, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.

C. The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

D. At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.

E. If the insured pays premiums for the long-term care insurance policy or certificate through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.

F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid, at the address provided by the insured for purposes of receiving notice of lapse or termination. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.

G. Reinstatement. In addition to the requirement in subsections (A) through (D), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of a lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate. Reinstatement after termination for other than unintentional lapse shall be governed by A.R.S. § 20-1348.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1005 recodified from R4-14-1005 (Supp. 95-1). Section R20-6-1005 renumbered to R20-6-1006; new Section R20-6-1005 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1006. Inflation Protection

A. An insurer shall not offer a long-term care insurance policy unless the insurer offers to the policyholder, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. The terms of the required provision shall be no less favorable than one of the following:

1. A provision that provides for annual increases in benefit levels compounding annually at a rate of not less than 5%;
2. A provision that guarantees an insured the right to periodically increase benefit levels without providing evidence of insurability or health status, if the insured did not decline the option for the previous period. The increased benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning from the purchase of the existing benefit and extending until the year in which the offer is made; or
3. A provision for coverage of a specified percentage of actual or reasonable charges that is not subject to a maximum specified indemnity amount or limit.

B. If the policy is issued to a group, the insurer shall extend the offer required by subsection (A) to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group, other than to a continuing care retirement community, the insurer shall make the offer to each proposed certificateholder.

C. An insurer is not required to make the offer in subsection (A) for life insurance policies or riders with accelerated long-term care benefits.

D. An insurer shall include the information listed in this subsection 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 provide a revised schedule of attained-age premiums. An insurer may use a reasonable hypothetical or a graphic demonstration for this disclosure.

E. Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time the person has been insured under the policy.

F. An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless the insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.

H. A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I reviewed Plans [insert description of plans], and I reject inflation protection."

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1006 recodified from R4-14-1006 (Supp. 95-1). R20-6-1006 renumbered to R20-6-1007; new Section R20-5-1006 renumbered from R20-6-1005 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1007. Required Disclosure Provisions

A. Riders and endorsements. Except for riders or endorsements by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, if an insurer adds a rider or endorsement to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy, the insurer shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall require the signed written agreement of the insured unless the increased benefits or coverage are required by law. If the insurer charges a separate additional premium for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

B. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall define the terms and explain them in its accompanying outline of coverage.

C. Disclosure of tax consequences. For life insurance policies that provide an accelerated benefit for long-term care, an insurer shall provide a disclosure statement 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. This subsection shall not apply to qualified long-term care insurance contracts.

D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The long-term care insurance policy shall describe these terms and provisions in a separate paragraph in the policy labeled "Eligibility for the Payment of Benefits" that includes and explains:

1. Any additional benefit triggers,
2. Benefit triggers that result in payment of different benefit levels, and
3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.

E. A long-term care insurance contract shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3. The contract shall also include a Specification Page which shall include the benefits, amounts, durations, the premium rate including all optional benefits selected by the insured, and any other benefit data applicable to the insured.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1007 recodified from R4-14-1007 (Supp. 95-1). Former Section R20-6-1007 renumbered to R20-6-1010; new Section R20-6-1007 renumbered from R20-6-1006 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1008. Required Disclosure of Rating Practices to Consumers

A. This Section applies as follows:

1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.

B. Unless a policy is one for which an insurer cannot increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy may be subject to rate increases in the future.
2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option if a premium rate revision occurs.
3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
4. A general explanation for applying premium rate or rate schedule adjustments that includes:
   a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
   b. The insurer's right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state that, at a minimum, identifies:
   a. The policy forms for which premium rates have been increased;
   b. The calendar years when the form was available for purchase; and
   c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).

C. An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:

1. Blocks of business acquired from other nonaffiliated insurers, and
2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.

D. If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005, or the end of a 24-month period following the

acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.

E. Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.

F. An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.

G. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1008 recodified from R4-14-1008 (Supp. 95-1). Former Section R20-6-1008 renumbered to R20-6-1011; new Section R20-6-1008 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1009. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after May 10, 2005.

B. At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide to the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:

1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
2. The policy design and coverage provided have been reviewed and taken into consideration;
3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
4. The premiums contain at least the minimum margin for moderately adverse experience as defined in subsection (4)(a) or the specification of and justification for a lower margin as required by subsection (4)(b).
   a. A composite margin shall not be less than 10% of lifetime claims.
   b. A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
   c. A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.
   d. A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.
5. A statement that the premium rate schedule:
   a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or
   b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences; and
6. A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
   a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
   b. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

C. An actuarial memorandum shall be included that is signed by a member of the Academy of Actuaries and that addresses and supports each specific item required as part of the actuarial certification and provides at least the following:

1. An explanation of the review performed by the actuary prior to making the statements in subsections (B)(2) and (B)(3);
2. A complete description of pricing assumptions;
3. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subsection (B)(1) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. The actuary shall clearly describe deviations in margins between ages, sexes, plans or states. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and
4. A demonstration that the gross premiums include the minimum composite margin specified in subsection (B)(4).

D. In any review of the actuarial certification and actuarial memorandum, the Director may request review by an actuary with experience in long-term care pricing who is independent of the insurer. In the event the Director asks for additional information as a result of any review, the period in A.R.S. § 20-1691.08 does not include the period during which the insurer is preparing the requested information.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1009 recodified from R4-14-1009 (Supp. 95-1). Section R20-6-1009 renumbered to R20-6-1012; new Section R20-6-1009 made by final rulemaking at 10 A.A.R. 4661,

effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1010. Requirements for Application Forms and Replacement Coverage; Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates; Reporting Requirements

A. An insurer's application form for a long-term care insurance policy shall include the questions listed in this Section 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 health or long-term care policy or certificate presently in force. An insurer may include the questions in a supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer. For a replacement policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the insurer may modify the questions only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the certificateholder 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 or certificate?

B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.

C. An insurance producer shall list any other health insurance policies the insurance producer has sold to the applicant, including:

1. Policies that are still in force, and
2. Policies sold in the past five years that are no longer in force.

D. Solicitations Other than Direct Response. On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer; shall furnish the applicant, before issuing or delivering the individual long-term care insurance policy, a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage. The insurer shall:

1. Give one copy of the notice to the applicant, and
2. Keep an additional copy signed by the applicant.

E. Direct Response Solicitations. Insurers using direct response solicitation methods as defined in A.R.S. § 20-1661 shall deliver a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy.

F. If replacement is intended, the replacing insurer shall send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy by name of the insurer and the insured, and policy number or insured's address including zip code.

G. A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with A.R.S. Title 20, Chapter 6, Article 1.1.

H. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits if similar exclusions are satisfied under the original policy.

I. Reporting requirements.

1. An insurer shall maintain the following records for each insurance producer:
   a. The amount of the insurance producer's replacement sales as a percent of the insurance producer's total annual sales, and
   b. The amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.
2. No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department:
   a. The 10% of its insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by subsection (I)(1);
   b. The number of lapsed policies as a percent of the total annual sales and as a percent of the insurer's total number of policies in force as of the end of the preceding calendar year;
   c. The number of replacement policies sold as a percent of the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and
   d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

J. In subsection (I):

1. "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.
3. "Policy" means only long-term care insurance.
4. "Report" means on a statewide basis.

K. 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. Reports required under this Section shall be filed with the Director.

L. Annual rate certification requirements. This subsection applies to any long-term care policy issued in Arizona on or after November 10, 2017. The following annual submission requirements apply subsequent to initial rate filings for indi-

vidual long-term care insurance policies made under this Section:

1. An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries which contains a statement of the sufficiency of the current premium rate schedule, including:
   a. For the rate schedules currently marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated or a statement that margins for moderately adverse experience may no longer be sufficient. For a statement that margins for moderately adverse experience may no longer be sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the Director within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the Director to withdraw or modify approval of the form for future sales pursuant to A.R.S. § 20-1691.08.
   b. For the rate schedules that are no longer marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions or that the premium rate schedule may no longer be sufficient. If the premium rate schedule is no longer sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including time frame, for the re-establishment of adequate margins for moderately adverse experience;
2. A description of the review performed that led to the statement; and
3. An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
   a. A detailed explanation of the data sources and review performed by the actuary prior to making the statement in subsection (L)(1),
   b. A complete description of experience assumptions and their relationship to the initial pricing assumptions,
   c. A description of the credibility of the experience data, and
   d. An explanation of the analysis and testing performed in determining the current presence of margins.
4. The actuarial certification required pursuant to subsection (L)(1) must be based on calendar year data and submitted annually starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to subsection (L)(3) must be submitted at least once every three years with the certification.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1010 recodified from R4-14-1010 (Supp. 95-1). R20-6-1010 renumbered to R20-6-1013; new Section R20-6-1010 renumbered from R20-6-1007 and amended by final by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1011. Prohibition Against Post-claims Underwriting

A. An application for a long-term care insurance policy or certificate that is not guaranteed issue shall meet the requirements of this Section.
1. The application shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.
   a. If the application has a question asking whether the applicant has had medication prescribed by a physician, the application shall also ask the applicant to list the prescribed medication.
   b. If the insurer knew or reasonably should have known that the medications listed in the application are related to a medical condition for which coverage would otherwise be denied, the insurer shall not rescind the policy or certificate for that condition.
2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block: "**Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.**"
3. The policy or certificate shall contain, at the time of delivery, the following language, or language substantially similar to the following, set out conspicuously: "**Caution: The issuance of this long-term care insurance [policy] [certificate] is based on 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].**"

B. Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain one of the following:
1. A report of a physical examination,
2. An assessment of functional capacity,
3. An attending physician's statement, or
4. Copies of medical records.

C. The insurer or its insurance producer shall deliver a copy of the completed application or enrollment form, as applicable, to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant it at the time of application.

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

E. On or before March 31 of each year, an insurer shall report the following information to the Director for the preceding calendar year, using the form prescribed in Appendix G:
1. Insurer 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 claim submitted,
f. Date of rescission, and
g. Detailed reason for rescission; and
3. Signature, name and title of the preparer, and date prepared.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1011 recodified from R4-14-1011 (Supp. 95-1). R20-6-1011 renumbered to R20-6-1014; new Section R20-6-1011 renumbered from R20-6-1008 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1012. Reserve Standards

A. If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders, an insurer shall determine policy reserves for long-time care benefits under A.R.S. § 20-510. An insurer shall also establish claim reserves for a policy or rider in claim status.

B. An insurer shall base reserves for policies and riders under subsection (A) on the multiple decrement model using all relevant decrements except for voluntary termination rates. An insurer may use single decrement approximations if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. The insurer shall not set the reserves for the long-term care benefit and the life insurance benefit to 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 Section, an insurer shall give due regard to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which impact projected claim costs including 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,
19. Guaranteed insurability option, and
20. Other similar or comparable factors affecting risk.

D. A member of the American Academy of Actuaries shall certify an insurer's use of any applicable valuation morbidity table as appropriate as a statutory valuation table.

E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves under A.R.S. § 20-508.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1012 recodified from R4-14-1012 (Supp. 95-1). R20-6-1012 renumbered to R20-6-1016; new Section R20-6-1012 renumbered from R20-6-1009 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section repealed; new Section renumbered from R20-6-1013 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1013. Loss Ratio

A. This Section applies to policies and certificates issued any time prior to May 10, 2005.

B. Benefits under an individual long-term care insurance policy are deemed reasonable in relation to premiums if the expected loss ratio is at least 60% calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the director shall consider 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.

C. A premium rate schedule or proposed revision to a premium rate schedule that is expected to produce, over the lifetime of the long-term care insurance policy, benefits that are less than 60% of the proposed premium rate schedule is deemed to be unreasonable.

D. Subsections (B) and (C) do not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
2. The portion of the policy that provides life insurance benefits complies with the nonforfeiture requirements of A.R.S. § 20-1231;
3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
   a. A description of the basis on which the long-term care rates were determined;
   b. A description of the basis for the reserves;
   c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
   d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include per-

cent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed, including:

i. Time of underwriting;

ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and

iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and

h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1013 recodified from R4-14-1013 (Supp. 95-1). Section R20-6-1013 renumbered to R20-6-1017; new Section R20-6-1013 renumbered from R20-6-1010 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1013 renumbered to R20-6-1012; new Section R20-6-1013 renumbered from R20-6-1014 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1014. Premium Rate Schedule Increase

A. This Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005 and prior to November 10, 2017.

B. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:

1. Information required by R20-6-1008;

2. Certification by a qualified actuary that:

a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

b. The premium rate filing complies with the provisions of this Section; and

c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.

3. An actuarial memorandum justifying the rate schedule change request that includes:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:

i. Any assumptions that deviate from those used for pricing other forms currently available for sale;

ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;

iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and

iv. A demonstration of compliance with subsection (C).

b. For exceptional increases, the actuarial memorandum shall also include:

i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;

c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;

d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;

e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;

f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and

g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and

5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;

2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:

a. The accumulated value of the initial earned premium times 58%;

b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

c. The present value of future projected initial earned premiums times 58%; and

d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;

3. If a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) shall also include 70% for exceptional rate increase amounts; and
4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).

D. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder in lieu of filing with the Director.

E. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.

F. If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.

G. If the majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:

1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the conditions in subsections (H) through (J); and
2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (C) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsections (C)(2)(a) and (C)(2)(c).

H. For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:

1. The rate increase is not the first rate increase requested for the specific policy form or forms,
2. The rate increase is not an exceptional increase, and
3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.

I. If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:

1. Be based on actuarially sound principles, but not on attained age;
2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
3. Allow the insured the option of retaining the existing coverage.

J. The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.

K. If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:

1. Filing and marketing comparable coverage for a period of up to five years, and
2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

L. Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
   a. A.R.S. Title 20, Chapter 6, Article 1.2; and
   b. A.R.S. Title 20, Chapter 16, Article 2;

5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
   a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
   b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
   c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
   d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   e. The estimated average annual premium per policy and the average issue age;
   f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
      i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
      ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
   g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

M. Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:
1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1014 recodified from R4-14-1014 (Supp. 95-1). Section repealed; R20-6-1014 renumbered from R20-6-1011 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1014 renumbered to R20-6-1013; new Section R20-6-1014 renumbered from R20-6-1015 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1015. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

A. This Section applies to any long-term care policy or certificate issued in this state on or after November 10, 2017.

B. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:
1. Information required by R20-6-1008;
2. Certification by a qualified actuary that:
   a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
   b. The premium rate filing complies with the provisions of this Section; and
   c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
3. An actuarial memorandum justifying the rate schedule change request that includes:
   a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
      i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
      ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
      iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
      iv. A demonstration of compliance with subsection (C).
   b. For exceptional increases, the actuarial memorandum shall also include:
      i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
   c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
   d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
   e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;
   f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
   g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted.
4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and

5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
2. The insurer shall calculate premium rate increases such that the sum of the lesser of either the accumulated value of the actual incurred claims (without the inclusion of active life reserves) or the accumulated value of historic expected claims (without the inclusion of active life reserves) plus the present value of the future expected incurred claims (projected without the inclusion of active life reserves) will not be less than the sum of the following:
   a. The accumulated value of the initial earned premium times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
   b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
   c. The present value of future projected initial earned premiums times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
   d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;
3. Historic expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Historic expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Historic expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
4. In the event that a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) will also include 70% for exceptional rate increase amounts; and
5. All present and accumulated values used to determine rate increases, including the lifetime loss ration consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in A.R.S. § 20-508. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.

E. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.

F. If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.

G. If the majority of policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to approval by the Director, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. Otherwise, the Director may impose the conditions in subsections (H) through (J).

H. For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:

1. The rate increase is not the first rate increase requested for the specific policy form or forms;
2. The rate increase is not an exceptional increase; and
3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.

I. If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:

1. Be based on actuarially sound principles, but not on attained age; and
2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
3. Allow the insured the option of retaining the existing coverage.

J. The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and

2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.

K. If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years; and
2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

L. Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
   a. A.R.S. Title 20, Chapter 6, Article 1.2; and
   b. A.R.S. Title 20, Chapter 16, Article 2.
5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
   a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
   b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
   c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
   d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   e. The estimated average annual premium per policy and the average issue age;
   f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
      i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
      ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
   g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

M. Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:
1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1015 recodified from R4-14-1015 (Supp. 95-1). Section R20-6-1015 renumbered to R20-6-1022; new Section R20-6-1015 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1015 renumbered to R20-6-1014; new Section R20-6-1015 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1016. Filing Requirements for Group Policies

A. Out-of-State Policies. Before an insurer or similar organization may offer group long-term care insurance to a resident of this state under A.R.S. § 20-1691.02(D), the insurer or organization shall file with the Director evidence that a state with statutory or regulatory long-term care insurance requirements substantially similar to those of this state has approved the group policy or certificate for use in that state.

B. Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1016 recodified from R4-14-1016 (Supp. 95-1). Section R20-6-1016 renumbered to R20-6-1023; new Section R20-6-1016 renumbered from R20-6-1012 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1017. Standards for Marketing

A. Every insurer marketing long-term care insurance coverage in this state, directly or through an insurance producer shall:
1. Establish marketing procedures to assure that any comparison of policies by its insurance producers is fair and accurate, and that 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 to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations;"
3. Provide the applicant with copies of the disclosure forms in Appendices A and B;
4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance;
5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(D)(3);
6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the

name, address, and phone number for the SHIP, at the time of solicitation; and

7. Establish auditable procedures for verifying compliance with this subsection (A).

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 or any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

C. An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

Historical Note

New section R20-5-1017 renumbered from R20-6-1013 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1018. Suitability

A. This Section does not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the "issuer") shall:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant,
2. Train its insurance producers in the use of its suitability standards, and
3. Maintain a copy of its suitability standards and make them available for inspection upon the Director's request.

C. To determine whether an applicant meets an issuer's suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:

1. The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
3. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

D. The issuer shall make reasonable efforts to obtain the information set out in subsection (C), including giving the applicant the "Long-Term Care Insurance Personal Worksheet" prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.

E. An issuer shall not consider an applicant for coverage until the issuer has received the applicant's completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

F. No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.

G. The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.

H. An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.

I. When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance." The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.

J. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent to purchase the long-term care policy. The issuer shall have either the applicant's returned Appendix I letter or a record of the alternative method of verification as part of the applicant's file.

K. The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (J).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1019. Nonforfeiture Benefit Requirement

A. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the following requirements:

1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (E); and
2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if the non-forfeiture benefit offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (D)(4) shall still apply.

D. Contingent Benefit Upon Lapse.

1. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
2. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
3. The contingent benefit on lapse is triggered when:
   a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
   b. The policy or certificate lapses within 120 days of the due date of the increased premium.
   c. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase		
Issue Age		**Percent Increase Over Initial Premium**
29 and under		200%
30-34		190%
35-39		170%
40-44		150%
45-49		130%
50-54		110%
55-59		90%
60		70%
61		66%
62		62%
63		58%
64		54%
65		50%
66		48%
67		46%
68		44%
69		42%
70		40%
71		38%
72		36%
73		34%
74		32%
75		30%
76		28%
77		26%
78		24%
79		22%
80		20%
81		19%
82		18%
83		17%
84		16%
85		15%
86		14%
87		13%
88		12%
89		11%
90 and over		10%

4. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period when:
   a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
   b. The policy or certificate lapses within 120 days of the due date of the increased premium; and
   c. The ratio in subsection (D)(6)(b) is 40% or more.
   d. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase on policies with a fixed or limited premium paying period		
Issue Age		**Percent Increase Over Initial Premium**
Under 65		50%
65-80		30%
Over 80		10%

   e. This provision shall be in addition to the contingent benefit provided by subsection (D)(3) and where both are triggered, the benefit provided shall be at the option of the insured.
5. On or before the effective date of a substantial premium increase as defined in subsection (D)(3), an insurer shall:
   a. Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
   b. Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (E), which the insured may elect at any time during the 120-day period referenced in subsection (D)(3); and
   c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(3) is deemed to be the election of the offer to convert under subsection (5)(b) unless the automatic option in subsection (D)(6)(c) applies.
6. On or before the effective date of a substantial premium increase on policies with a fixed or limited premium paying period as defined in subsection (D)(4), an insurer shall:
   a. Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;

b. Offer to convert the coverage to paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. The insured may elect this option at any time during the 120-day period referenced in subsection (D)(4); and
c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(4) is deemed to be the election of the offer to convert under subsection (D)(6)(b) if the ratio is 40% or more.

7. For any long-term care policy issued on or after November 10, 2017, that an insurer issued at least 20 years prior to the effective date of a substantial premium increase, the insurer shall use a rate increase value of 0% in place of all values in the above tables.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (D)(3) but not subsection (D)(4), mean any of the following:

1. Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least 1% per year before age 50, and at least 3% per year beyond age 50.
2. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (E)(3).
3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (F).
4. When the nonforfeiture benefit begins.
   a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
   b. Notwithstanding subsection (E)(4)(a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
      i. The end of the tenth year following the policy or certificate issue date, or
      ii. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

G. There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.

H. The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:

1. Except as provided in subsection (H)(2) and (H)(3), this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.
3. The provisions of this Section that apply to fixed or limited premium paying period policies shall only apply to policies issued on or after November 10, 2017.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1013, R20-6-1014 or R20-6-1015, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (D)(3) or (D)(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.

K. An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:

1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption;
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
   a. Reduced paid-up premiums,
   b. Extended term insurance,
   c. Shortened benefit period, or
   d. Other similar offerings that the Director has approved.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1020. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

B. Activities of daily living shall include at least the following as defined in R20-6-1003(A)(1) and in the policy:

1. Bathing,
2. Continence,

3. Dressing,
4. Eating,
5. Toileting, and
6. Transferring.

C. An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.

D. An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A), (B) and (C).

E. For purposes of this Section the determination of a deficiency shall not be more restrictive than:
1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.

F. Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.

G. The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after January 10, 2005.
2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts

A. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner, which is not subject to approval or modification by the insurer.

B. A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

C. Licensed health care practitioners shall perform the certified determinations regarding activities of daily living and cognitive impairment required under subsection (B).

D. Certified determinations required under subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1022. Standard Format Outline of Coverage

A. The outline of coverage prescribed in A.R.S. § 20-1691.06 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material.

B. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that give prominence equivalent to capitalization or underscoring.

C. An insurer shall use the text and sequence of text in the standard format outline of coverage prescribed in Appendix J, unless otherwise specifically indicated.

Historical Note

New Section R20-6-1022 renumbered from R20-6-1015 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1023. Requirement to Deliver Shopper's Guide

A. All prospective applicants of a long-term care insurance policy or certificate shall receive a long-term care insurance shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners.
1. In the case of insurance producer solicitation, an insurance producer shall deliver the shopper's guide before presenting an application or enrollment form.
2. In the case of direct response solicitations, the insurer shall provide the shopper's guide with any application or enrollment form.

B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection (A), but shall receive the policy summary required under A.R.S. § 20-1691.06.

Historical Note

New Section R20-6-1023 renumbered from R20-6-1016 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1024. Availability of New Health Care Services or Providers

A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or heath care providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.

B. Notwithstanding subsection (A), notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

C. The insurer shall make the new coverage available in one of the following ways:
1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age:

2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
4. By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders who purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to R20-6-1010(A), (C) through (G) and R20-6-1018 and are not subject to the reporting requirements of R20-6-1010(I)(1), (I)(2)(a) through (I)(2)(c).

F. Where an employer, labor organization, professional, trade or occupational association offers the policy, the required notification in subsection (A) shall be made to the offering entity. However, if the policy is issued to a group defined in A.R.S. § 20-1691(5), the notification shall be to each certificateholder.

G. Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium, to add such new services or providers.

H. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

I. This Section shall become effective on or after November 10, 2017.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1024 renumbered to R20-6-1026; new Section R20-6-1024 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1025. Right to Reduce Coverage and Lower Premiums

A. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
1. Reducing the maximum benefit; or
2. Reducing the daily, weekly or monthly benefit amount.

B. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

C. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

D. The provision in subsection (A) shall include a description of the process for requesting and implementing a reduction in coverage.

E. The premium for the reduced coverage shall:
1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force, and
2. Be consistent with the approved rate table.

F. The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

G. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by R20-6-1005(F).

H. This Section does not apply to life insurance policies or riders containing accelerated long-term benefits.

I. The requirements of subsections (A) through (H) shall apply to any long-term care policy issued in this state on or after November 10, 2017.

J. A premium increase notice required by R20-6-1008(G) shall include:
1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this Section;
2. A disclosure stating that all options available to the policyholder may not be of equal value; and
3. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

K. The requirements of subsection (J) shall apply to any rate increase implemented in this state on or after November 10, 2017.

Historical Note

New Section R20-6-1025 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1026. Instructions for Appendices

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

Historical Note

New Section R20-6-1026 renumbered from R20-6-1024 by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix A. Long-term Care Insurance Personal Worksheet

Long-term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers_____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____
[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History
The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 50%?]

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one) ☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000] ☐$[30-50,000] ☐Over $50,000

(Drafting Instruction: The issuer may choose the numbers to put in the brackets to fit its suitability standards.)

How do you expect your income to change over the next 10 years? (check one)
☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐From my Income ☐From my Savings/Investments ☐My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____Approximate cost $_____for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐From my Income ☐From my Savings/Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation. **or** ☐ I choose not to complete this information. (Check one.)
☐ I acknowledge that the carrier and/or its insurance provider (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:_____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed:_____ _____
(Insurance Producer) (Date)

Insurance Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My insurance provider has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: _____ _____
(Applicant) (Date)

(Drafting Instruction: Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.)
The company may contact you to verify your answers.

(Drafting Instruction: When the Long-term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the document may be removed.)

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix A renumbered to Appendix C; new Appendix A made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix B. Long-term Care Insurance Potential Race Increase Disclosure Form

Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][$_____])
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy**.
3. **Rate Schedule Adjustments**:
   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions**:
   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- ☐ Pay the increased premium and continue your policy in force as is.
- ☐ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- ☐ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- ☐ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**
If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:
You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%

63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix B renumbered to Appendix D; new Appendix B made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix C. Notice to Applicant Regarding Replacement of Individual Health or Long-term Care Insurance

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL HEALTH 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 health 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) 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 health 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 [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:
Use additional sheets, as necessary.)

I have reviewed your 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 that you may presently have (preexisting conditions), may not be immediately or fully covered under your 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 of 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 properly recorded.

_____
(Signature of Insurance Producer or Other Representative)

(Typed Name and Address of Insurance Producer)

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). New Appendix C renumbered from Appendix A and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix D. Notice to Applicant Regarding Replacement of Health or Long-term Care Insurance

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH 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 health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want 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 health 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.

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, even though 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 insurance producer 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.

Historical Note

New Appendix D renumbered from Appendix B and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix E. Long-Term Care Insurance Replacement and Lapse Reporting Form

Long-term Care Insurance
Replacement and Lapse Reporting Form

For the State of_____
For the Reporting Year of_____

Company Name: _____ Due: June 30 annually
Company Address:_____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

Instructions
The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) the amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the 10% of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements as % of Number of Policies Sold By This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

Company Totals
Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

Historical Note
New Appendix E made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix F. Long-term Care Insurance Claims Denial Reporting Form

Long-term Care Insurance
Claims Denial Reporting Form

For the State of_____
For the Reporting Year of_____

Company Name:_____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____Phone Number: _____
Line of Business: Individual Group

Instructions
The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

☐ Per Claimant - counts each individual who makes one or a series of claim requests
☐ Per Transaction - counts each claim payment request

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	**Nationwide Data[1]**
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

		State Data	**Nationwide Data[1]**
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Historical Note
New Appendix F made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix G. Rescission Reporting Form for Long-term Policies

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES

FOR THE STATE OF _____
FOR THE REPORTING YEAR _____

Company Name_____
Address:_____
_____
Phone Number:_____
Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:
_____
_____
_____
_____

_____
Signature

_____
Name and Title (please type)

_____
Date

Historical Note
New Appendix G made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

Appendix H. Things You Should Know Before You Buy Long-term Care Insurance

Things You Should Know Before You Buy Long-term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
	• [**WARNING!** You should **not** buy this insurance policy unless you can afford to pay the premiums every year. You are making a multi-year financial commitment.] [Remember that the company can increase premiums in the future.]

(Drafting Instruction: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
	• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	• Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	• Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments. and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Historical Note

New Appendix H made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix I. Long-term Care Insurance Suitability Letter

Long-term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(**Drafting Instruction:** Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Instruction: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____
APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

Historical Note

New Appendix I made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

Appendix J. Long-term Care Insurance Outline of Coverage

[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, shall 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. FEDERAL TAX CONSEQUENCES
   This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.
   OR
   Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE].is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.
4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED
   (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
      (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
      (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
   (b) [For group coverage, 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;]
5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.
   [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]
6. 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.]
7. 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 insurance producers] Neither [insert company name] nor its [agents or insurance producers] 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.
8. 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.]
9. 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.]
   (d) Eligibility for Payment of Benefits
   [Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined

and described as part of the outline of coverage.]
[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.
[Describe:
(a) Preexisting conditions;
(b) Non-eligible facilities and providers;
(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
(d) Exclusions and exceptions;
(e) Limitations.]
[This Section shall 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.

11. 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) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
12. 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.]
13. 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.]
14. ADDITIONAL FEATURES.
[(a)Indicate if medical underwriting is used;
(b)Describe other important features.]
15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Historical Note

New Appendix J renumbered from Appendix C and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Incorporation by Reference and Modifications

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, August 2016 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 100 N. 15th Ave., Suite 102, Phoenix, AZ 85007-2624 and available from the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:
   a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
   b. "Commissioner" means the Director of the Arizona Department of Insurance.
   c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(7).
   d. "Regulation" means Article.
2. Section 3(A)(2) reads:
   (2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state including association plans.
3. Section 8(A)(7)(c) reads:
   c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or 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 of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.
4. Section 8.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
   The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1,

2010 remain subject to the requirements of A.R.S. § 20-1133.

5. Section 8.1(A)(7)(c) is revised to read as follows:
   Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or 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.
6. Section 9.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
   The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.
7. Section 9.2 is revised to insert the citation to A.R.S. § 20-1133 as follows:
   The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of A.R.S. § 20-1133.
8. Section 15(G) is revised as follows:
   An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology.
9. Section 23 is revised as follows:
   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). R20-6-1101 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). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 15 A.A.R. 996, effective June 2, 2009 (Supp. 09-2). Amended by final rulemaking at 25 A.A.R. 1923, effective September 8, 2019 (Supp. 19-3).

R20-6-1102. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1102.01 Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1103. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1104. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1105. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1106. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1107. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1108. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1109. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1110. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1111. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1112. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1113. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1114. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1115. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1116. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1117. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1118. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1119. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1120. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1121. Repealed

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). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix A. Repealed

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 A repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix B. Repealed

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 B repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix C. Repealed

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 C repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005

(Supp. 05-3).

Appendix D. Repealed

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 repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix E. Repealed

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 E repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix F. Repealed

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). Appendix F repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

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. "The Act" means the Insurance Holding Company Systems Act, A.R.S. §§ 20-481 through 20-481.32.

B. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

C. "Ultimate controlling person" means that person which is not controlled by any other person.

D. Unless the context otherwise requires, other terms found in these regulations and in A.R.S. § 20-481 are used as defined in the Act. Other nomenclature or terminology is according to Title 20, A.R.S. or industry usage if not defined by Title 20, A.R.S.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 recodified from R4-14-1401 (Supp. 95-1).
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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 and on Form E, attached hereto as Appendix E, and described in subsections (D) and (E) of this section.

B. The applicant shall promptly advise the Director of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Director's disposition of the application.

C. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of A.R.S. § 20-481.02(G), the name of the domestic insurer on the cover page should be indicated as follows: "[ABC Insurance Company), a

subsidiary of [XYZ Holding Company]." Where a A.R.S. § 20-481.02(G) 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.

D. If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to A.R.S. § 20-481.02(A), that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to A.R.S. § 20-481.25(C).

E. Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to A.R.S. § 20-481.25, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of A.R.S. § 20-481.25 as set forth in A.R.S. § 20-481.25(B).

F. In addition to the information required by Form E, the Director may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1402 recodified from R4-14-1402 (Supp. 95-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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 G.

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 amendment 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). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1404. Summary of Registration – Statement Filing

An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 is also required to furnish information required on Form C, attached hereto as Appendix C.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1404 recodified from R4-14-1404 (Supp. 95-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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 under A.R.S. § 20-481.09. A registration statement may include information not required by the Act 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. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, 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 A.R.S. §§ 20-481.15 or 20-481.16 without obtaining the prior approval of the Director. The Director, however, reserves the right to require individual filings if he or she 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). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;
3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;
4. A statement explaining why the 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 receipt of 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). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1407. Transactions Subject to Prior Notice – Notice Filing

A. 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 G.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;
2. Set forth the methods to allocate costs;
3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
6. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;
7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;
8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
9. Include standards for termination of the agreement with and without cause;
10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;
11. Specify that, if the insurer is placed in receivership or seized by the Director under the Arizona Receivership Act:
    a. All of the rights of the insurer under the agreement extend to the receiver or Director; and,
    b. All books and records will immediately be made available to the receiver or the Director, and shall be turned over to the receiver or Director immediately upon the receiver or Director's request;
12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the Arizona Receivership Act; and
13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Director under the Arizona Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1407 recodified from R4-14-1407 (Supp. 95-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1408. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to A.R.S. § 481.10(D) shall furnish the required information on Form F, attached hereto as Appendix F.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1408 recodified from R4-14-1408 (Supp. 95-1). R20-6-1408 repealed; new Section R20-6-1408 made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1409. 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 an explanation of the basis for valuation;
4. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:
    a. The amounts, dates and form of payment of all dividends or distributions, including regular dividends but excluding distributions of the insurer's own securities, paid within the period of 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 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 relative to the insurer's financial needs.

B. Subject to A.R.S. § 20-481.19, each registered insurer shall report to the Director all dividends and other distributions to shareholders within 5 business days following the declaration thereof and at least 10 business days before payment of the dividend or distribution, including the same information required by subsection (A)(4)(a) through (e) of this rule.

Historical Note

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 23 A.A.R 3311, effective January 16, 2018 (Supp. 17-4).

R20-6-1410. Adequacy of Surplus

The factors set for in A.R.S. §§ 20-481.01(F) and 20-481.24 are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Director instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Director will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Director will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Historical Note

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix A. Form A - Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer

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:_____, 20____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

_____

ITEM 1. METHOD OF ACQUISITION

[State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired. 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

[On the biographical affidavit, include a third party background check, and state the following with respect to (1) 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.

(a) Name and business address;

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, officer or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on: if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case;

Such persons may 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 the contracts, arrangements or understandings have been entered into.]

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

[Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid 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, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]

[(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five 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. The statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the 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 the state.]

[(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Appendix G.)

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

[Signature and 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 _____, 20_____.

(SEAL)

Name of Applicant

BY _____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20_____, for and on behalf of _____; 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 the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix B. Form B - Insurance Holding Company System Annual Registration Statement

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: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

[Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the 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 control. As to each person specified in the chart or listing, indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.]

ITEM 3. THE ULTIMATE CONTROLLING PERSON

[As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) The principal business of the person;

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.]

ITEM 4. BIOGRAPHICAL INFORMATION

[If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his

or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.]

ITEM 5. TRANSACTIONS AND AGREEMENTS

[Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and

(i) Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of A.R.S. § 20-481.09.

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 the 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 the 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.a. 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 7.b. STATEMENT REGARDING CORPORATE GOVERNANCE AND INTERNAL CONTROLS

[The insurer shall furnish a statement that the insurer's board of directors oversees corporate governance and internal controls of the insurer and that the insurer's officers or senior management have approved, implemented and maintain and monitor corporate governance and internal control procedures.]

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) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Director. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Director otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Forms B and G.]

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. § 20-481.09, Registrant _____ has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____day of _____, 20_____.

(SEAL)

Name of Applicant

BY _____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20_____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix C. Form C - Summary of Registration Statement

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies
Name Address

_____
_____
_____
_____

Dated:_____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____

[Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 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:]

Pursuant to the requirements of A.R.S. § 20-481.09, Registrant _____ has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20____.

(SEAL)

Name of Applicant

BY_____
(Name)

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix D. Form D - Prior Notice of a Transaction

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

_____
_____
_____
_____

Dated:_____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

[Furnish the following information for each of the parties to the transaction:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.;

(e) A description of the nature of the parties' business operations;

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.]

ITEM 2. DESCRIPTION OF THE TRANSACTION

[Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under A.R.S. § 20-481.12(B);

(b) A statement of the nature of the transaction;

(c) If a notice for amendments or modifications, the reasons for the change and the financial impact on the domestic insurer;

(d) A statement of how the transaction meets the "fair and reasonable" standard of A.R.S. § 20-481.12(A)(1); and

(e) 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 funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 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, as described by A.R.S. § 20-481.12(B)(3)(b), or a reinsurance pooling agreement or modification thereto as described by A.R.S. § 20-481.12(B)(3)(a), 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, or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years, 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. Notice shall be given for all reinsurance pooling agreements including modifications thereto.]

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

[For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed;

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.]

[For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;

(b) A description of the period of time during which the agreement is to be in effect;

(c) A brief description of each party's expenses or costs covered by the agreement;

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement;]

(e) A brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

(f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and

(g) A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.]

ITEM 7. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.09, _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____on the _____ day of _____, 20_____.

(SEAL)

By_____
Name of Applicant

_____
(Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20_____, for and on behalf of _____; 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 the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix E. Form E - Pre-acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-domiciliary Insurer Doing Business in this State or by a Domestic Insurer

PRE-ACQUISITION NOTIFICATION FORM
REGARDING THE POTENTIAL COMPETITIVE IMPACT
OF A PROPOSED MERGER OR ACQUISITION BY A
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS
STATE OR BY A DOMESTIC INSURER

_____
Name of Applicant

_____
Name of Other Person Involved in Merger or Acquisition

Filed with the Arizona Department of Insurance
Dated:_____, 20_____
Name, title, address and telephone number of person completing this statement:
_____
_____
_____
_____

ITEM 1. NAME AND ADDRESS
[State the name and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.]

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES
[State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.]

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION
[State the nature and purpose of the proposed merger or acquisition.]

ITEM 4. NATURE OF BUSINESS
[State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.]

ITEM 5. MARKET AND MARKET SHARE
[State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in A.R.S. § 20-481.25(D). If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.]

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

Historical Note
Adopted effective February 22, 1993 (Supp. 93-1). Appendix E. *Instructions on Forms,* renumbered to Appendix G; new Appendix E. Form E made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix F. Form F - Enterprise Risk Report

ENTERPRISE RISK REPORT

Filed with the Arizona Department of Insurance

_____
Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies
Name Address
_____
_____
_____
_____
Dated:_____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:
_____
_____
_____

ITEM 1. ENTERPRISE RISK

[The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in A.R.S. § 20-481(4), provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities with the insurance holding company system;

Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;

Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system'

Business plan of the insurance holding company system and summarized strategies for next 12 months;

Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

Identification of insurance holding company system capital resources and material distribution patterns;

Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (include both the rating score and outlook);

Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

[The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.]

ITEM 2. OBLIGATION TO REPORT

[If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.]

Historical Note

Appendix F, Form F made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix G. Instructions on Forms A, B, C, D, E and F

INSTRUCTIONS ON FORMS A, B, C, D, E AND F

FORMS - GENERAL REQUIREMENTS

Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by A.R.S. §§ 20-481.02, 20-481.09, 20-481.12 and 20-481.25. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether 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.

One original paper statement excluding exhibits, and all other papers and documents shall be filed with the Director. The statement shall be signed in the manner prescribed on the form. 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. All paper filings shall be by personal delivery or mail addressed to: Arizona Department of Insurance, Financial Affairs Division.

In addition to the filed paper statement, a copy of the statement, including exhibits, and all other papers and documents filed as a part thereof, shall be filed electronically.

All filed documents shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

If an applicant requests a hearing on a consolidated basis under A.R.S. § 20-481.07, in addition to filing the Form A with the Director, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

FORMS - INCORPORATION BY REFERENCE, SUMMARIES AND OMMISSIONS

Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document 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 the 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 the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

FORMS - INFORMATION UNKNOWN OR UNAVAILABLE AND EXTENSION OF TIME TO FURNISH

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there 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.

FORMS - ADDITIONAL INFORMATION AND EXHIBITS

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Director may request such further 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 forms. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: “Change No. (insert number) to” and shall indicate the date of the change and not the date of the original filing.

Historical Note

Appendix G. *Instructions on Forms,* renumbered from Appendix E. *Instructions on Forms,* with heading amended to include new Appendix F, by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

ARTICLE 15. RESERVED

ARTICLE 16. CREDIT FOR REINSURANCE

R20-6-1601. Credit for Reinsurance – Reinsurer Licensed in Arizona

Pursuant to A.R.S. § 20-261.05(B), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in Arizona as of any date on which statutory financial statement credit for reinsurance is claimed.

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). Amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1602. Credit for Reinsurance – Accredited Reinsurers

A. Pursuant to A.R.S. § 20-261.05(C), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in Arizona as of the date on which statutory financial statement credit for reinsurance is claimed.

B. An accredited reinsurer must:

1. File a properly executed Form AR-1, attached as Appendix A to this Article, as evidence of its submission to the Director's jurisdiction and to the Director's authority to examine its books and records;
2. File with the Director a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
3. File annually with the Director a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and
4, Maintain a surplus as regards policyholders in an amount not less than $20 million, or obtain the affirmative approval of the Director upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

C. If the Director determines that the assuming insurer has failed to meet or maintain any of these qualifications, the Director may upon written notice and opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this Section if the assuming insurer's accreditation has been revoked by the Director, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the Director.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1602 recodified from R4-14-1602 (Supp. 95-1). R20-6-1602 renumbered to R20-6-1607; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1603. Credit for Reinsurance – Reinsurer Domiciled in Another State

A. Pursuant to A.R.S. § 20-261.05(D), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial credit for reinsurance is claimed:

1. Is domiciled in (or, in the case of a U.S. branch of an alien assuming insurer, is entered through) a state that employs standards regarding credit for reinsurance substantially similar to those applicable under A.R.S. §§ 20-261.01 through 20-261.08 and this Article;
2. Maintains a surplus as regards policyholders in an amount not less than $20 million; and
3. Files a properly executed From AR-1 (Exhibit A) with the Director as evidence of the submission to the Director's authority to examine its books and records.

B. The provisions of this Section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this Section, "substantially similar" standards means credit for reinsurance standards that the Director determines equal or exceed the standards of A.R.S. §§ 20-261.01 through 20-261.08 and this Article.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1603 recodified from R4-14-1603 (Supp. 95-1). R20-6-1603 renumbered to R20-6-1608; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1604. Credit for Reinsurance – Reinsurers Maintaining Trust Funds

A. Pursuant to A.R.S. § 20-261.05(E), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified U.S. financial institution as defined in A.R.S. § 20-261.03, for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Director substantially the same information as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by licensed insurers, to enable the Director to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million, except as provided in subsection (B)(2) of this Section.
2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of

U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities, attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

3. The trust fund for a group including incorporated and individual unincorporated underwriters:
   a. Shall consist of:
      i. For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;
      ii. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this Article, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and
      iii. In addition to these trusts, the group shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.
   b. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Director:
      i. An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or
      ii. If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.
4. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10 billion (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall:
   a. Consist of funds in trust in an amount no less than the assuming insurers'
      several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;
   b. Maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and
   c. File a properly executed Form AR-1 (Exhibit A) as evidence of the submission to the Director's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.
   d. Within ninety days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the Director an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group.

C. Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.

1. The trust instrument shall provide that:
   a. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty days after entry of the final order of any court of competent jurisdiction in the United States;
   b. Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;
   c. The trust shall be subject to examination as determined by the commissioner;
   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, shall have outstanding obligations under reinsurance agreements subject to the trust; and
   e. No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.
2. Notwithstanding any other provisions in the trust instrument;
   a. If the trust fund is inadequate because it contains an amount less than the amount required by this Section or if the granter of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.
   b. The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with

the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

c. If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the clams of the U.S. beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

D. For purposes of this Section, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include:

1. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:
   a. Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;
   b. Reserves for losses reported and outstanding;
   c. Reserves for losses incurred but not reported;
   d. Reserves for allocated loss expenses; and
   e. Unearned premiums.
2. For business ceded by domestic insurers authorized to write life, health and annuity insurance:
   a. Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;
   b. Aggregate reserves for accident and health policies;
   c. Deposit funds and other liabilities without life or disability contingencies; and
   d. Liabilities for policy and contract claims.

E. Assets deposited in trusts established pursuant to A.R.S. § 20-261.05 and this Section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in A.R.S. § 20-261.03, clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution as defined in A.R.S. § 20-261.03, and investments of the type specified in this subsection (E), but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed 5% of total investments. No more than 20% of the total of the investments in the trust may be foreign investments authorized under subsections (E)(1)(e), (E)(3), (E)(6)(b) or (E)(7) of this Section, and no more than 10% of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of A.R.S. § 261.05 shall be invested only as follows:

1. Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:
   a. The United States or by any agency or instrumentality of the United States;
   b. A state of the United States;
   c. A territory, possession or other governmental unit of the United States;
   d. An agency or instrumentality of a governmental unit referred to in subsections (E)(1)(b) and (E)(1)(c) of this Section if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this subsection (E)(1)(d) if payable solely out of special assessments on properties benefited by local improvements; or
   e. The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
2. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:
   a. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;
   b. Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in Arizona and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or
   c. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;
3. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
4. An investment made pursuant to the provisions of subsections (E)(1), (E)(2) or (E)(3) of this Section shall be subject to the following additional limitations;
   a. An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed 5% of the assets of the trust;
   b. An investment in any one mortgage-related security shall not exceed 5% of the assets of the trust;
   c. The aggregate total investment in mortgage-related securities shall not exceed 25% of the assets of the trust; and
   d. Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under subsections (E)(2)(a) and (E)(2)(c) of this Section, but shall not exceed 2% of the assets of the trust.

5. As used in this Section:
   a. "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:
      i. Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that: (1) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and (2) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1703; or
      ii. Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of subsection (E)(5)(a)(i) of this Section;
   b. "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.
6. Equity interests.
   a. Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:
      i. Its obligations and preferred shares, if any, are eligible as investments under this Section; and
      ii. The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. 78a - 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this Section an amount exceeding 1% of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;
   b. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:
      i. All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and
      ii. The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;
   c. An investment in or loan upon any one institution's outstanding equity interests shall not exceed 1% of the assets of the trust. The cost of an investment in equity interests made pursuant to this subsection (E)(6), when added to the aggregate cost of other investments in equity interests then held pursuant to this subsection (E)(6), shall not exceed 10% of the assets in the trust;
7. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.
8. Investment companies
   a. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. 80a, are permissible investments if the investment company:
      i. Invests at least 90% of its assets in the types of securities that qualify as an investment under subsection (E)(1), (E)(2) or (E)(3) of this Section or invests in securities that are determined by the Director to be substantively similar to the types of securities set forth in subsection (E)(1), (E)(2) or (E)(3) of this Section; or
      ii. Invests at least 90% of its assets in the types of equity interests that qualify as an investment under subsection (E)(6)(a) of this Section;
   b. Investments made by a trust in investment companies under this subsection (E)(8) shall not exceed the following limitations:
      i. An investment in an investment company qualifying under subsection (E)(8)(a)(i) of this Section shall not exceed 10% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed 25% of the assets in the trust, and
      ii. Investments in an investment company qualifying under subsection (E)(8)(a)(ii) of this Section shall not exceed 5% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to subsection (E)(6)(a) of this Section.
9. Letters of Credit
   a. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for

the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

b. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

F. A specific security provided to a ceding insurer by an assuming insurer pursuant to Section R20-6-1606 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this Section.

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). R20-6-1604 renumbered to R20-6-1609; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1605. Credit for Reinsurance – Certified Reinsurers

A. Pursuant to A.R.S. §§ 20-261.05(F), (G) and (H), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in Arizona at all times for which statutory financial statement credit for reinsurance is claimed under this Section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the Director. The security shall be in a form consistent with the provisions of A.R.S. §§ 20-261.05(F), (G) and (H), 20-261.06 and Sections R20-6-1608, R20-6-1609 or R20-6-1610. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

1.

Ratings	Security Required
Secure-1	0%
Secure-2	10%
Secure-3	20%
Secure-4	50%
Secure-5	75%
Vulnerable-6	100%

2. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.
3. The Director shall require the certified reinsurer to post 100%, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.
4. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the Director. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:
   a. Line 1: Fire
   b. Line 2: Allied Lines
   c. Line 3: Farmowners multiple peril
   d. Line 4: Homeowners multiple peril
   e. Line 5: Commercial multiple peril
   f. Line 9: Inland Marine
   g. Line 12: Earthquake
   h. Line 21: Auto physical damage
5. Credit for reinsurance under this Section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this Section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.
6. Nothing in this Section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this Section.

B. Certification Procedure

1. The Director shall post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The Director may not take final action on the application until at least thirty days after posting the notice required by this subsection (B)(1).
2. The Director shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with subsection A of this Section. The Director shall publish a list of all certified reinsurers and their ratings.
3. In order to be eligible for certification, the assuming insurer shall meet the following requirements:
   a. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the Director pursuant to subsection C of this Section.
   b. The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250 million calculated in accordance with subsection (B)(4)(h) of this Section. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250 million and a central fund containing a balance of at least $250 million.
   c. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the Director. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the Director in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:
      i. Standard & Poor's;
      ii. Moody's Investors Service;
      iii. Fitch Ratings;
      iv. A.M. Best Company; or

v. Any other Nationally Recognized Statistical Rating Organization.

d. The certified reinsurer must comply with any other requirements reasonably imposed by the Director.

4. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

a. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The Director shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

Ratings	**Best**	**S&P**	**Moody's**	**Fitch**
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

b. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

c. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

d. For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (instructions attached as Exhibit C) (for property/casualty reinsurers) or Form CR-S (instructions attached as Exhibit D) (for life and health reinsurers);

e. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

f. Regulatory actions against the certified reinsurer;

g. The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(4)(h) below;

h. For certified reinsurers not domiciled in the U.S., audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the Director, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor). Upon the initial application for certification, the Director will consider audited financial statements for the last three years filed with its non-U.S. jurisdiction supervisor;

i. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;

j. A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The Director shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

k. Any other information deemed relevant by the Director.

5. Based on the analysis conducted under subsection (B)(4)(e) of this Section of a certified reinsurer's reputation for prompt payment of claims, the Director may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the Director shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under subsection (B)(4)(a) of this Section if the Director finds that:

a. more than 15% of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety days or more which are not in dispute and which exceed $100 thousand for each cedent; or

b. the aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety days or more exceeds $50 million.

6. The assuming insurer must submit a properly executed Form CR-1 (attached as Exhibit B) as evidence of its submission to the jurisdiction of Arizona, appointment of the Director as an agent for service of process in Arizona, and agreement to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The Director shall not certify any assuming insurer that is domiciled in a jurisdiction that the Director has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

7. The certified reinsurer must agree to meet applicable information filing requirements as determined by the Director, both with respect to an initial application for certification and on an ongoing basis. All information

submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under A.R.S. § 20-158 and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

a. Notification within ten days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;
b. Annually, Form CR-F or CR-S, as applicable;
c. Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(7)(d) below;
d. Annually, audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the Director, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor). Upon the initial certification, audited financial statements for the last three years filed with the certified reinsurer's supervisor;
e. At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;
f. A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and
g. Any other information that the Director may reasonably require.

8. Change in Rating or Revocation of Certification.
   a. In the case of a downgrade by a rating agency or other disqualifying circumstance, the Director shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of subsection (B)(4)(a) of this Section.
   b. The Director shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this Section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the Director to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.
   c. If the rating of a certified reinsurer is upgraded by the Director, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Director shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Director, the Director shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.
   d. Upon revocation of the certification of a certified reinsurer by the Director, the assuming insurer shall be required to post security in accordance with Section R20-6-1607 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with Section R20-6-1604, the Director may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the Director to be at high risk of uncollectibility.

C. Qualified Jurisdictions.

1. If, upon conducting an evaluation under this Section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the Director determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the Director shall publish notice and evidence of such recognition in an appropriate manner. The Director may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.
2. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the Director shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The Director shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the Director as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the Director with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the Director, include but are not limited to the following:
   a. The framework under which the assuming insurer is regulated.
   b. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
   c. The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
   d. The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
   e. The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the Director in particular.
   f. The history of performance by assuming insurers in the domiciliary jurisdiction.
   g. Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the Director has determined that it does not adequately and

promptly enforce final U.S. judgments or arbitration awards.

h. Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.

i. Any other matters deemed relevant by the Director.

3. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The Director shall consider this list in determining qualified jurisdictions. If the Director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Director shall provide thoroughly documented justification with respect to the criteria provided under subsections (C)(2)(a) through (i) of this Section.

4. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.

1. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Director has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 (Exhibit B) and such additional information as the Director requires. The assuming insurer shall be considered to be a certified reinsurer in Arizona.

2. Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in Arizona as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the Director of any change in its status or rating within ten days after receiving notice of the change.

3. The Director may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with subsection (B)(8) of this Section.

4. The Director may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the Director suspends or revokes the certified reinsurer's certification in accordance with subsection (B)(8) of this Section, the certified reinsurer's certification shall remain in good standing in this State for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in Arizona.

E. Mandatory Funding Clause. In addition to the clauses required under Section R20-6-1611, reinsurance contracts entered into or renewed under this Section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this Section for reinsurance ceded to the certified reinsurer.

F. The Director shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1605 recodified from R4-14-1605 (Supp. 95-1). R20-6-1605 renumbered to R20-6-1610; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1606. Credit for Reinsurance Required by Law

Pursuant to A.R.S. § 20-261.05(I), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. §§ 20-261.05(B) through (H) but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this Section, "jurisdiction" means state, district or territory of the United States and any lawful national government.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1606 recodified from R4-14-1606 (Supp. 95-1). R20-6-1606 renumbered to R20-6-1611; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1607. Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer not Meeting the Requirements of Sections R20-6-1601 through R20-6-1606

A. Pursuant to A.R.S. § 20-261.06, the Director shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. § 20-261.05 in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in A.R.S. § 20-261.03. This security may be in the form of any of the following:

1. Cash;

2. Securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

3. Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in A.R.S. § 20-261.03, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

4. Any other form of security acceptable to the Director.

B. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this Section shall be allowed only when the requirements of Section R20-6-1611 and the applicable portions of Sections R20-6-1608, R20-6-1609 or R20-6-1610 have been satisfied.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1607 recodified from R4-14-1607 (Supp. 95-1). Section R20-6-1607 renumbered to R20-6-1612; new Section R20-6-1607 renumbered from R20-6-1602 and amended

by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1608. Trust Agreements Qualified under Section R20-6-1607

A. As used in this Section:
1. "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.
2. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.
3. "Obligations," as used in subsection (B)(11) of this Section, 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.
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 in subsections (B)(11) and (12) of this Section.
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 ten 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 thirty days, but not more than forty-five 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 domiciled.
9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.
10. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.
11. Notwithstanding other provisions of this Section, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:
   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 ten 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 subsections (11)(a) and (b) above as may remain executory after such

withdrawal and for any period after the termination date.

12. Notwithstanding other provisions of this Section, when a trust agreement is established to meet the requirements of Section R20-6-1607 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:
    a. To pay or reimburse the ceding insurer for:
        i. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and
        ii. The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provision of the policies reinsured under the reinsurance agreement.
    b. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer, or
    c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in subsections (12)(a) and (b) above as may remain executory after withdrawal and for any period after the termination date.
13. Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed 5% of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this subsection must be included in the reinsurance agreement.

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 ninety days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety days after the trustee and the beneficiary receive 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 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 that the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in subsection (D)(1)(b) of this Section.
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. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, 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:
1. A reinsurance agreement 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. 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;
    c. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and
    d. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies; and
ii. To pay or reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and
iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding reinsurer; or
iv. To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

2. The reinsurance agreement also may contain provisions that:
a. Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:
i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the 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 current fair market value of the trust account is no less than 102% of the required amount.
b. Provide for the return of any amount withdrawn in excess of the actual amounts required for subsection (D)(1)(d) of this Section, and for interest payments at a rate not in excess of the prime rate of interest on such amounts;
c. Permit the award by any arbitration panel or court of competent jurisdiction of:
i. Interest at a rate different from that provided in subsection (D)(2)(b) of this Section;
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 Article 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 Article, any trust agreement or underlying reinsurance agreement in existence and approved by the Director prior to the effective date of this Article will continue to be acceptable until December 31, 2016, at which time the agreements will have to fully comply with this Section for the trust agreement to be acceptable.

G. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (A)(1) of this Section shall not be construed to affect any actions or rights that the Director may take or possess pursuant to the provisions of the laws of Arizona.

Historical Note
New Section R20-6-1608 renumbered from R20-6-1603 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1609. Letters of Credit Qualified under Section R20-6-1607.

A. The letter of credit must be clean, irrevocable, unconditional and issued or confirmed by a qualified United States financial institution as defined A.R.S. § 20-261.03. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subsection (H)(1) of this Section. As used in this Section, "beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

B. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

C. A letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

D. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for no less than thirty days' notice prior to expiration date or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of Arizona or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), This incorporation by reference contains no future additions or amendments. All drafts of letters of credit drawn according to UCP 600 or ISP98 shall be presentable at an office in the United States of a qualified United States financial institution.

F. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of UCP 600 occur.

G. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in subsection A of this Section, then the following additional requirements shall be met:
1. The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and
2. The "evergreen clause" shall provide for thirty days notice prior to expiration date or nonrenewal.

H. Reinsurance agreement provisions.
1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:
   a. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;
   b. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:
      i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;
      ii. To pay or reimburse the ceding insurer for the assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and
      iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;
      iv. Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in subsections (H)(1)(b)(i), (ii) and (iii) of this Section as may remain after withdrawal and for any period after the termination date.
   c. All of the provisions of subsections (H)(1)(a) and (b) of this Section shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.
2. Nothing contained in subsection (H)(1) of this Section shall preclude the ceding insurer and assuming insurer from providing for:
   a. An interest payment, at a rate not in excess of the prime rate of interest on the amounts held pursuant to subsection (H)(1)(b) of this Section; or
   b. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

Historical Note
New Section R20-6-1609 renumbered from R20-6-1604 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1610. 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
New Section R20-6-1610 renumbered from R20-6-1605 by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-1611. Reinsurance Contract
Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections R20-6-1601 through R20-6-1605 or R20-6-1607 of this Article or otherwise in compliance with A.R.S. § 20-261.05 after the adoption of this Article unless the reinsurance agreement:
1. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to A.R.S. § 20-261(C);
2. Includes a provision pursuant to A.R.S. § 20-261.05 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 the 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 the court or panel; and
3. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

Historical Note
New Section R20-6-1611 renumbered from R20-6-1606 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

R20-6-6012. Contracts Affected
All new and renewal reinsurance transactions entered into after the effective date of this Article shall conform to the requirements of A.R.S. §§ 20-261.01 through 20-261.08 and this Article if credit is to be given to the ceding insurer for such reinsurance.

Historical Note
New Section R20-6-1612 renumbered from R20-6-1607 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

Exhibit A. Form AR-1, Certificate of Assuming Insurer

FORM AR-1, CERTIFICATE OF ASSUMING INSURER

I,_____,_____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in

_____, hereby certify that
(name of state)
_____ ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in
_____
(ceding insurer's state of domicile)
for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Director of Insurance of the State of Arizona as its lawful attorney upon whom may be served any lawful process in any action, suit or legal proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Director of Arizona to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in
_____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.

Dated: _____

_____
(name of assuming insurer)
BY: _____
(name of officer)

_____
(title of officer)

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1). Exhibit A amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

Exhibit B. Form CR-1, Certificate of Certified Reinsurer

FORM CR-1, CERTIFICATE OF CERTIFIED REINSURER

I, _____,_____
(name of officer) (title of officer)
of_____, the assuming insurer under
(name of assuming insurer)

a reinsurance agreement with one or more insurers domiciled in_____
(name of state)
in order to be considered for approval in this state, hereby certify that
_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____for the adjudication of any issue arising out of the (ceding insurer's state of domicile) reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____ (ceding insurer's state of domicile) as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with this Article.

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with this Article.

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated:_____

_____
(name of assuming insurer)

_____
(name of officer)

_____
(title of officer)

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). Exhibit B repealed; new Exhibit B made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

Exhibit C. Form CR-F Instructions

Form CR-F Instructions

Part 1 - Assumed Reinsurance as of December 31, Current Year (000 Omitted)
Create a spreadsheet with the following columns (total each column 5 through 15):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsured
4. Domiciliary Jurisdiction
5. Assumed Premium
6. Reinsurance on Paid Losses and Loss Adjustment Expenses
7. Reinsurance on Known Case Losses and LAE
8. Cols. 6 + 7
9. Contingent Commissions Payable
10. Assumed Premium Receivable
11. Unearned Premium
12. Funds Held By or Deposited With Reinsured Companies
13. Letters of Credit Posted
14. Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit
15. Amount of Assets Pledged or Collateral Held in Trust

Each row shall list each insurer for which reinsurance is assumed for the calendar year.

Part 2 - Ceded Reinsurance as of December 31, Current Year (000 Omitted)
Create a spreadsheet with the following columns (total each column 6 through 19):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsurer
4. Domiciliary Jurisdiction
5. Reinsurance Contracts Ceding 75% or More of Direct Premiums Written
6. Reinsurance Premiums Ceded
7. Reinsurance Recoverable on Paid Losses
8. Reinsurance Recoverable on Paid LAE
9. Reinsurance Recoverable on Known Case Loss Reserves
10. Reinsurance Recoverable on Known Case LAE Reserves
11. Reinsurance Recoverable on IBNR Loss Reserves
12. Reinsurance Recoverable on IBNR LAE Reserves
13. Reinsurance Recoverable on Unearned Premiums
14. Reinsurance Recoverable on Contingent Commissions
15. Cols. 7 through 14 Totals
16. Reinsurance Payable Ceded Balances Payable
17. Reinsurance Payable Other Amounts Due to Reinsurers
18. Net Amount Recoverable From Reinsurers, Cols. 15 – [16 + 17]
19. Funds Held by Company Under Reinsurance Treaties

Each row shall list each insurer to whom reinsurance was ceded for the calendar year.

Historical Note

Exhibit C made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

Exhibit D. Form CR-S Instructions

Form CR-S Instructions

Part 1 – Section 1. Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year
Create a spreadsheet with the following columns (total each column 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Location
6. Type of Reinsurance Assumed
7. Amount of In Force at End of Year
8. Reserve
9. Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies, and related benefits) for the calendar year.

Part 1 – Section 2. Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

Please create a spreadsheet with the following columns (total columns 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Domiciliary Jurisdiction
6. Type of Reinsurance Assumed
7. Premiums
8. Unearned Premiums
9. Reserve Liability Other Than For Unearned Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (accident and health insurance) for the calendar year.

Part 2. Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 6 and 7):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Paid Losses
7. Unpaid Losses

Each row shall list each insurer for which reinsurance on paid and unpaid losses is recoverable.

Part 3 – Section 1. Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year
Create a spreadsheet with the following columns (total each column 7 through 14):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date

4. Name of Company
5. Location
6. Type of Reinsurance Ceded
7. Amount in Force at End of Year
8. Reserve Credit Taken Current Year
9. Reserve Credit Taken Prior Year
10. Premiums
11. Outstanding Surplus Relief Current Year
12. Outstanding Surplus Relief Prior Year
13. Modified Coinsurance Reserve
14. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies and related benefits).

Part 3 – Section 2. Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year
Create a spreadsheet with the following columns (total each column 7 through 13):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Type
7. Premiums
8. Unearned Premiums (Estimated)
9. Reserve Credit Taken other than for Unearned Premiums
10. Outstanding Surplus Relief Current Year
11. Outstanding Surplus Relief Prior Year
12. Modified Coinsurance Reserve
13. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (accident and health insurance).

Historical Note

Exhibit D made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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 shall examine an insurer under A.R.S. § 20-156(A) at least once every five years.

B. Instead of the examination under subsection (A), the Director may accept the most recent examination report prepared by the National Association of Insurance Commissioners insurance regulatory authority of another state on any foreign or alien insurer if:

1. The insurance regulatory authority was accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program at the time of the examination,
2. A National Association of Insurance Commissioners accredited insurance regulatory authority supervised the examination, or
3. At least one examiner employed or contracted by a National Association of Insurance Commissioners accredited insurance regulatory authority:
   a. Participated in and reviewed the examination work papers and report, and
   b. Signed an affidavit stating that the examination was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners accredited 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). Amended by final rulemaking at 11 A.A.R. 2975, effective September 10, 2005 (Supp. 05-3).

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. This Article applies to:
1. All proposed and existing health care services organizations (HCSOs), and
2. Each product offered by an HCSO under the HCSO's certificate of authority.

B. The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.
C. The Department shall not require an existing HCSO to re-file information already on file with the Department, but the HCSO shall modify its operations and procedures as may be necessary to comply with this Article and file with the Department all additional information necessary to make statements complete and current.
D. This Article applies to inpatient emergency care, but does not apply to emergency services.
E. This Article applies only to covered services.

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1902. Definitions
In this Article, the following definitions apply:

"Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.

"Adult" means an enrollee in the age group the HCSO has designated for an adult.

"Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.

"Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical supplies dispensed by order or prescription of a provider with the appropriate prescribing authority.

"Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.

"Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization according to applicable legal requirements and policies approved by the governing authority.

"Child" means an enrollee in the age group the HCSO has designated for children.

"Contracted" means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.

"Covered" or "covered services" means the health care services described as covered benefits in the HCSO's evidence of coverage.

"Day" means calendar day unless specified otherwise.

"Department" means the Department of Insurance.

"Effective process" means written policies and procedures that:

Outline the steps that the HCSO implements and consistently follows internally,

The HCSO subjects to internal quality improvement, and

The HCSO communicates to providers when established or changed.

"Emergency services" has the meaning in A.R.S. § 20-2801(3).

"Enrollee" means an individual who is enrolled in a health plan operated by an HCSO.

"Facility" means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.

"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 HCSO is vested.

"HCSO" means a health care services organization.

"Health care services" has the meaning in A.R.S. § 20-1051(6).

"High profile" means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.

"Hospital" means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.

"Inpatient care" means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.

"Inpatient emergency care" means covered services that would be emergency services if provided in a licensed hospital emergency facility.

"License" means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.

"Medically necessary" has the meaning set forth in the HCSO's evidence of coverage.

"Network" means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO's health benefit plan.

"Network exception" means an enrollee receives covered services from a non-contracted provider either:

Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or

For any reason the HCSO determines it is in the enrollee's best interests to receive care from a non-contracted provider.

"Non-contracted" means a provider that does not have a contract with an HCSO to provide services to an enrollee.

"Normal business hours" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.

"Outpatient care" means covered services that an enrollee who is not an inpatient receives.

"Pediatric primary care provider" means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.

"Physician" means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.

"Practitioner" means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.

"Preventive care" means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:

Immunizations,

Health education,

Health evaluation and follow-up,

Early disease detection,

Screening tests appropriate for a person's age and gender, and

Periodic health care examinations.

"Primary care" means any specialty the HCSO designates as primary care.

"Primary care physician" or "PCP" means a physician or practitioner practicing in a specialty the HCSO designates as primary care.

"Provider" means any physician, practitioner, ancillary provider, or facility.

"Quality improvement" means an HCSO's system for assessing and improving the level of performance of key process and outcomes.

"Routine care" means covered primary care for an enrollee's non-urgent, symptomatic condition.

"Rural" means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

"Service area" means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).

"Specialty care provider" or "SCP" means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.

"Specialty" or "specialty care" means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician's or practitioner's license.

"Special hospital" means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.

"Suburban area" means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.

"Telemedicine" means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication.

"Timely" means services are provided at the time when medically necessary.

"Travel expenses" has the meaning set forth in writing by an HCSO.

"Urban area" means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

"Urgent care" means unscheduled services for an enrollee's condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1903. Documentation

The 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). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1904. Health Care Plan

A. An HCSO shall submit a statement to the Department that describes the proposed health care plan.

B. The HCSO shall have an organized system for the delivery of health care services contained in subsection (D) that includes the following:
1. Contracted providers that provide services under the plan;
2. An effective process to promote a continuing relationship between an enrollee and the same PCP; and
3. An effective process for referrals that ensures continuity of care to an enrollee.

C. The HCSO shall list:
1. The proposed or actual enrollment;
2. The number and names of contracted, employed, or HCSO-owned providers that will serve the enrollees and the board eligibility or certification of each physician, if applicable; and
3. The plan for providing covered services to enrollees as required under this Article.

D. The HCSO's health care plan shall provide within the geographic area served the following basic health care services covered by the monthly charges in the evidence of coverage:
1. Emergency care that includes emergency services and inpatient emergency care;
2. Inpatient care;
3 Specialty care, primary care, or ancillary care that includes diagnostic and therapeutic services;
4. Outpatient care;
5. Preventive care; and
6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.

E. The HCSO shall provide appropriate coverage for out-of-area emergency care to an enrollee 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). R20-6-1904 repealed; new Section R20-6-1904 renumbered and amended from R20-6-1906 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1905. Geographic Area

A. An applicant shall describe the proposed geographic area in at least one of the following ways:
1. Legal description,
2. Local governmental jurisdiction such as city or county,
3. Census tracts,
4. Street boundaries, or
5. Area within a specified radius of a specified intersection or a specified primary care center.

B. An applicant shall submit a map that shows the boundaries for the proposed geographic area.

C. An applicant shall submit a description of the proposed network including the data required under R20-6-1913(A)(2) and (A)(3).

D. All advertising matter and sales material provided a prospective enrollee 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). R20-6-1905 repealed; new Section R20-6-1905 renumbered and amended from R20-6-1907 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1906. Chief Executive Officer

A. The governing authority shall appoint a CEO who has appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO is the appointed representative of the governing authority and is the executive officer of the HCSO.

B. The CEO shall have at least the following duties and responsibilities:
1. Manage the HCSO;
2. Establish and implement policies, procedures, and effective processes of the HCSO;

3. Act as liaison between the governing authority and the providers of healthcare 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 ensure that all HCSO employees and contracted providers 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). Section R20-6-1906 renumbered to R20-6-1904; new Section R20-6-1906 renumbered and amended from R20-6-1908 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1907. 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 responsibilities include:
1. Supervising medical staff;
2. Performance planning and evaluating medical staff;
3. Coordinating medical staff activities; and
4. Developing medical care policies.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6--1907 renumbered to R20-6-1905; new Section R20-6-1907 renumbered and amended from R20-6-1909 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1908. Quality Assurance

A. The HCSO shall provide an effective process for a continuing review and evaluation of the covered services it provides to enrollees to ensure that:
1. Treatment and level of covered services are appropriate and adequate and
2. The quality of covered services is acceptable to the HCSO.

B. The HCSO shall have a quality assurance committee that includes at least the CEO or designee, the medical director, and representative network providers. The quality assurance committee shall:
1. Arrange for physicians or practitioners to review and evaluate covered services provided by others physicians or practitioners within the respective disciplines.
2. Adopt administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports.

C. The HCSO's effective process in subsection (A) shall include the following:
1. Standards for health care;
2. Monitoring of care;
3. Analysis of any deficiency;
4. Correcting a deficiency including submitting a schedule for correcting the deficiency, requiring continuing education for the provider, if appropriate, and follow-up and periodic reassessment of the deficiency.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1908 renumbered to R20-6-1906; new Section R20-6-1908 renumbered and amended from R20-6-1911, by final rulemaking at 11 A.A.R. 4861, effective December 31, 2006 (Supp. 05-4).

R20-6-1909. Evaluation of Network

Each HCSO shall have an effective process to evaluate the adequacy of its network to provide an enrollee with timely covered services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1909 renumbered to R20-6-1907; new Section R20-6-1909 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1910. Process for Referral, Prior Authorization, Precertification, or Network Exception

A. An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.

B. An HCSO shall have an effective process during normal business hours for handling referrals, prior authorizations, pre-certifications, or network exceptions necessary for timely routine care. This process may include the HCSO's procedure for standing referrals required in A.R.S. § 20-1057.01.

C. Each HCSO shall have an effective process to handle referrals or network exceptions necessary for timely urgent care seven days a week.

D. An HCSO that requires prior authorization or precertification for urgent care shall have an effective process to handle requests for prior authorization or precertification 24 hours a day, seven days a week.

E. An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1911. HCSO Communication with Providers

An HCSO shall have an effective process for communicating with contracted providers regarding the following:
1. The providers in the network,
2. Contractual or administrative changes relating to enrollee access or provider availability, and
3. Procedures for handling claims and grievances submitted by providers.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-

1911 renumbered to R20-6-1908; new R20-6-1911 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1912. Network Directories

A. An HCSO shall publish a provider network directory as follows:
1. An HCSO shall list the name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners.
2. An HCSO may list ancillary providers by corporate or group name and is not required to list individual physicians or practitioners.
3. An HCSO is not required to list physicians or practitioners in the following areas of specialties or areas of practice:
   a. Emergency medicine;
   b. Anesthesiology, except anesthesiologists who provide pain management services;
   c. Hospital-based pathology;
   d. Hospital-based radiology; and
   e. Hospitalists.
4. An HCSO that lists any of the physicians or practitioners in subsections R20-6-1912(A)(3)(a) through (A)(3)(e) may list by corporate or group name and is not required to list individual physicians or practitioners.
5. An HCSO that uses hospitalists is not required to list the hospital affiliations of PCPs who do not admit or attend hospitalized members.
6. An HCSO shall publish a provider network directory that lists all its contracted facilities and contains:
   a. The name, address, and telephone number of each facility;
   b. For each hospital at which the HCSO uses hospitalists, if any, a statement that the HCSO uses hospitalists at that hospital;
   c. For an HCSO that uses hospitalists and does not list them in the directory, information on how an enrollee can find out what hospitalists or group of hospitalists it uses at each hospital;

B. The network directory shall conspicuously state in the directory the following:
1. Changes occur in the network after the directory is published and some providers listed in the directory may no longer be contracted,
2. Enrollee coverage may depend on the contract status of the provider,
3. Where the enrollee can obtain more recent directory information,
4. The effective date of the network directory, and
5. The method for an enrollee or prospective enrollee to find out which PCPs are accepting new enrollees from the HCSO.

C. Each HCSO shall make its network directory available on paper to enrollees or prospective enrollees requesting it. The HCSO shall:
1. Publish the paper directory at least once a year;
2. Update or supplement the information in the paper directory at least every six months;
3. Explain in the paper directory how an enrollee or prospective enrollee can use or get assistance using the HCSO's online or telephone directories, if any; and
4. Have discretion to list physicians' or practitioners' hospital affiliations in its paper directory.

D. Each HCSO that has an online network directory shall:
1. Update the online directory at least monthly;
2. Make the online directory easy to use and user friendly; and
3. Explain, in the online directory, how an enrollee or prospective enrollee can obtain a paper directory.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1913. Demographic Information Reports

A. An HCSO shall report the following data to the Department:
1. For each enrollee, report annually:
   a. Street address,
   b. Zip code,
   c. Gender, and
   d. Year of birth.
2. For all contracted providers, report semiannually:
   a. Provider name,
   b. Street address or addresses at which the provider provides covered services,
   c. Zip code, and
   d. Arizona license number,
3. For all contracted physicians or practitioners, report semiannually:
   a. Specialty, and
   b. Medical or other applicable degree or information that designates the type of physician or practitioner.

B. The HCSO shall report the information in subsection (A) to the Department by the following deadlines:
1. For information in subsection (A)(1) as of December 31 of each calendar year, by February 15 of the next calendar year.
2. For information in subsection (A)(2) as of June 30, by August 15 of the same calendar year.
3. For information in subsection (A)(2) as of December 31, by February 15 of the next calendar year.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1914. Access

An HCSO shall provide to or arrange for its enrollees services or appointments for services as follows:
1. For preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule.
2. For routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request to the PCP or sooner if medically necessary.
3. For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary.
4. In-area urgent care services from a contracted provider seven days per week.
5. Timely non-emergency inpatient care services from a contracted facility.
6. Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care.
7. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6 1915. Alternative Access

A. As an alternative to providing access to covered services from a physician, an HCSO may provide access to covered services from an appropriately licensed practitioner.
B. As an alternative to providing access to covered services at a hospital under R20-6-1914, an HCSO may provide access to covered services at another appropriately licensed facility.
C. As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person under R20-6-1914, an HCSO may provide access to necessary covered services through:
1. Telephone calls and messages,
2. Electronic mail,
3. Communication with the physician's or practitioner's staff,
4. Coverage by another physician or practitioner, or
5. Telemedicine,

D. An HCSO that panels enrollees to PCPs may panel enrollees to appropriately licensed practitioners.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1916. Availability Ratios
A. An HCSO shall maintain a ratio of contracted adult PCPs to adults that is adequate to provide those adults with covered services. An HCSO with a Medicare Advantage (MA) plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.
B. An HCSO shall maintain a ratio of contracted pediatric PCPs to children that is adequate to provide those children enrollees with covered services.
C. An HCSO shall maintain a ratio of contracted high profile SCPs to enrollees that is adequate to provide those enrollees with covered services that include services at contracted facilities. An HCSO with a MA plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1917. Geographic Availability in an Urban Area
An HCSO shall provide each enrollee living in an urban area of the HCSO's service area the following:
1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and
3. Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1918. Geographic Availability in a Suburban Area
Each HCSO shall provide each enrollee member living in a suburban area within the HCSO's service area the following:
1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and
3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1919. Geographic Availability in a Rural Area
An HCSO shall provide each enrollee living in a rural area with primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1920. Travel Requirements
A. An HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. Nothing in this Section creates an exception to R20-6-1918 through R20-6-1920.
B. If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1921. Enforcement Consideration
In determining the appropriate enforcement action or penalties for failure to comply with these rules, the Department shall consider any documentation the HCSO provides regarding:
1. Whether seasonal shifts in demand affect access and availability of covered services;
2. Whether the HCSO's demographic information has changed significantly since the HCSO's most recent report;
3. Whether an enrollee has refused to accept covered services the HCSO has offered in the time-frames or locations required of the HCSO by this Article;
4. Whether an enrollee has requested and obtained covered services from a contracted provider whose location, or appointment availability, or capacity result in the HCSO's non-compliance; and
5. Whether market factors indicate that on a short-term basis, compliance is not possible. Market factors include shortage of providers, enrollee or provider location, and provider practice or contracting patterns.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

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, under A.R.S. § 20-1098, shall pay a nonrefundable fee of $1,000.00 to the Department for issuance of the license. A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of $1,000 for each participant contract application that establishes a protected cell under A.R.S. § 20-1098.05(B)(9). 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. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of $2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.

C. A captive insurer shall pay a nonrefundable fee of $200.00 to the Department at the time of filing for issuance of an amended certificate of authority.

D. 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 the Director conducts, under A.R.S. § 20-1098.08.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 2977, effective September 13, 2005 (Supp. 05-3). Subsection (A) corrected at request of the Department, Office File No. M11-252, filed July 20, 2011 (Supp. 11-3).

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).

ARTICLE 22. MILITARY PERSONNEL

R20-6-2201. Military Sales Practices

A. The Department incorporates by reference the National Association of Insurance Commissioners (NAIC) Military Sales Practices Model Regulation June 2007 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and available from the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108.

B. The Model Regulation is modified as follows:
1. In addition to the terms defined in the Model Regulation, the following definitions apply:
a. "Commissioner" means the Director of the Arizona Department of Insurance.
b. "Regulation" means Article.
2. Section 3 is modified to insert "A.R.S. § 20-106, 20-142 and 20-143" after "of."
3. Section 7(E)(5)(b) is modified to insert "A.R.S. § 20-1241 et seq., R20-6-202, and R20-6-209" after "requirements of."
4. Subsection 7(F)(5) of the Model Regulation is excluded from this Section.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 4215, effective January 5, 2008 (Supp. 07-4).

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

R20-6-2301. Applicability; Definitions

A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:
1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).

B. In this Article, the following definitions apply:
1. "Department" means the Arizona Department of Insurance.
2. "Blanket disability insurance" has the meaning prescribed in A.R.S. § 20-1404(A).
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Federal medical loss ratio standard" means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
5. "Health insurance" means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(5) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
6. "Health insurer" means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
7. "Individual health insurance" means health insurance that a health insurer issues to either:
a. An individual, to cover:
i. The individual, or
ii. The individual's dependents, or
iii. The individual and the individual's dependents.
b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
8. "PHS Act" means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
9. "Product" means a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurer offers as individual insurance in Arizona.
10. "Preliminary justification" means a justification that consists of the parts described in R20-6-2302(A).
11. "Rate increase" means an increase of the rates for an individual health insurance product that a health insurer offers in Arizona that:
a. Results from a change to the underlying rate structure of the product, and
b. May result in premium changes for the product.
12. "Secretary" means the Secretary of the United States Department of Health and Human Services.

13. "Threshold rate increase" means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
    a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
    b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.
14. "Threshold rate review" means the review by the Department under this Article of a threshold rate increase.
15. "Unreasonable rate increase" means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
    a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
    b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
    c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
    d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
    e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2302. Disclosure of Preliminary Justification

A. Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
    a. Historical and projected claims experience;
    b. Trend projections related to utilization, and service or unit cost;
    c. Any claims assumptions related to benefit changes;
    d. Allocation of the overall rate increase to claims and non-claims costs;
    e. Per enrollee per month allocation of current and projected premium; and
    f. Three year history of rate increases for the product associated with the rate increase.
2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
    a. An explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in subsection (A)(1); and
    b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

B. A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2303. Timing for Submission of Preliminary Justification

A. If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.

B. If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.

C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2304. Response to Unreasonableness Determination

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:
1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
    a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;
    b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer

shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary justification on the date the health insurer revises the rate increase filing or files a new rate increase; or

c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.

3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:
   a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the preliminary justification supporting the rate increase; and
   b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
      i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
      ii. The health insurer's final justification for implementing the rate increase.
   c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2305. Threshold Rate Increase Documentation Requirements

A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
2. The health insurer's data related to past projections and actual experience.

B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative costs;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical loss ratio;
12. The health insurance insurer's capital and surplus; and
13. Other relevant documentation at the discretion of the Director.

C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:
1. The health insurer submits the preliminary justification required under R20-6-2302, or
2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

ARTICLE 24. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

R20-6-2401. Definitions

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.
1. "Allowed Amount" is the amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements.
2. "Alternative Arbitrator" is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.
3. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for out-of-network copayment, coinsurance and deductible pursuant to the enrollee's health care policy.
4. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.
5. "A.R.S. § 20-3113 Disclosure" means a written, dated document that contains the following information:
   a. The name of the billing health care provider;
   b. A statement that the health care provider is not a contracted provider;
   c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;
   d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the A.R.S. § 20-3113 Disclosure to obtain health care services;
   e. A notice that if the enrollee or the enrollee's authorized representative signs the A.R.S. § 20-3113 Disclosure, they may have waived any rights to request

arbitration of a qualifying surprise out-of-network bill.

6. "Balance bill" means all charges that exceed the enrollee's cost sharing requirements and the amount paid by the insurer.
7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network bill.
8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.
9. "Department" means the Arizona Department of Insurance or an entity with which it contracts to administer the out-of-network claim dispute resolution process.
10. "Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative shall not be someone who represents the provider's interests.
11. "Final resolution of a health care appeal" means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.
12. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative.
13. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill for health care services provided on or after January 1, 2019, that is disputed by the enrollee and:
    a. Is for health care services covered by the enrollee's health plan;
    b. Is for health care services provided in a network health care facility;
    c. Is for health care services performed by a provider who is not contracted to participate in the network that serves the enrollee's health plan;
    d. The enrollee has resolved any health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;
    e. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the surprise out-of-network bill or the health care services provided;
    f. The amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least $1,000.00; and
    g. One of the following applies:
        i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);
        ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;
        iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure:
        iv. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;
        v. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;
        vi. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2402. Request for Arbitration

A. Request for Arbitration. An enrollee may request dispute resolution of a surprise out-of-network bill by filing a timely Request for Arbitration with the Department on a Request for Arbitration form available on the Department's website.

B. Deadline for filing a Request for Arbitration with the Department. A Request for Arbitration must be received by the Department within one year after the date of service listed on the surprise out-of-network bill. If the enrollee filed a health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, the one year deadline is tolled from the date the enrollee filed the health care appeal to the date of the final resolution of the appeal.

C. Evaluation of the Request for Arbitration by the Department. Within 15 days after receipt of a Request for Arbitration, the Department shall do one of the following:
1. Determine that the surprise out-of-network bill is a qualifying surprise out-of-network bill and notify the enrollee, health insurer and health care provider that the Request for Arbitration qualifies for Arbitration;
2. Determine that the surprise out-of-network bill is not a qualifying surprise out-of-network bill and notify the enrollee of the reason for the Department's determination;
3. Determine that the Request for Arbitration is incomplete; or
4. Return the Request for Arbitration to the enrollee without making a determination if the enrollee's request should instead be filed as a health care appeal within the meaning of A.R.S. Title 20, Chapter 15, Article 2.

D. Request for additional information for an incomplete Request for Arbitration. If the Department determines that the Request for Arbitration is incomplete, the Department may send a written request for additional information to the enrollee, health insurer, health care provider or health care provider's billing company.

E. Time to respond to the Department's Request for Additional Information. The enrollee, health insurer, health care provider or the health care provider's billing company shall have 15 days from the date of the request to respond to the Department's Request for Additional Information.

F. Failure to respond to the Department's Request for Additional Information.
1. If the enrollee fails to respond to the Department's Request for Additional Information, the Department shall deny the enrollee's Request for Arbitration.
2. If either the health insurer or the health care provider or health care provider's billing company fail to respond to the Department's Request for Additional Information, the Department shall deem that the enrollee's Request for Arbitration qualifies for arbitration.

G. Receipt of Additional Information. Upon receipt of the additional information requested by the Department under subsection (D) of this Section, the Department shall determine, within seven days, whether the enrollee's Request for Arbitration qualifies for Arbitration and send the notice required under subsection (C)(1) or subsection (C)(2) of this Section, whichever applies.

H. Final Determination. The Department's determination whether an enrollee's Request for Arbitration qualifies for Arbitration is a final decision and not an appealable agency action within the meaning of A.R.S. § 41-1092(3). A claim that is the subject of a qualifying surprise out-of-network bill is not subject to the timely payment of claims law during the pendency of the Arbitration.

I. Enrollee's payment responsibility.
1. Notwithstanding any informal settlement or Arbitrator's Final Written Decision, the enrollee is responsible for only the following:
   a. The amount of the enrollee's cost sharing requirements; and
   b. Any amount received by the enrollee from the enrollee's health insurer as payment for the health care services at issue in a qualifying surprise out-of-network bill.
2. A health care provider may not issue, either directly or indirectly through its billing company, any additional balance bill to the enrollee for the same health care services.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2403. Informal Settlement Teleconference

A. Deadline to arrange the Informal Settlement Teleconference. Upon a determination that an enrollee has made a Request for Arbitration that qualifies for Arbitration, the Department shall arrange an Informal Settlement Teleconference between the parties within 30 days of notifying the enrollee that the enrollee's Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).

B. Notice of Informal Settlement Teleconference. At least 14 days prior to the scheduled date, the Department shall send a Notice of Informal Settlement Teleconference to the enrollee, the enrollee's authorized representative, the health insurer, the health care provider and the health care provider's representative informing them of the date, time and instructions on how to participate in the Informal Settlement Teleconference.

C. Health Insurer documentation. On or before the Informal Settlement Teleconference, the health insurer shall provide to the parties the enrollee's cost sharing requirements under the enrollee's health plan based on the qualifying surprise out-of-network bill.

D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal Settlement Teleconference, it shall be subject to the following consequences:
1. If the health insurer, provider or provider's representative fails to participate in an Informal Settlement Teleconference scheduled by the Department, the participating party may notify the Department which shall promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.
2. If the enrollee or the enrollee's authorized representative fails to participate in the original Informal Settlement Teleconference, the original Informal Settlement Teleconference is terminated.
3. If the enrollee or the enrollee's authorized representative fails to participate in a rescheduled Informal Settlement Teleconference, the enrollee's Request for Arbitration is terminated.

E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. If the enrollee or the enrollee's representative fails to participate in the Informal Settlement Teleconference originally scheduled by the Department, the enrollee may request that the Department reschedule the Informal Settlement Conference. The enrollee's request to reschedule must be received by the Department within 14 days after the originally scheduled Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within the 14 day period terminates the enrollee's Request for Arbitration.

F. Notification to the Department after the Informal Settlement Teleconference. Within seven days after the date of the Informal Settlement Teleconference, the health insurer shall:
1. Notify the Department whether a settlement was reached between the parties; and
2. If a settlement was reached, notify the Department of the terms of the settlement on a form prescribed by the Department.

G. Failure to settle. If the parties fail to settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the Department shall arrange for the Arbitration.

H. Settlement. If the parties settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the health insurer shall remit its portion of the payment to the health care provider within 30 days after the Informal Settlement Teleconference. A claim that is reprocessed by a health insurer as a result of informal settlement is not in violation of A.R.S. § 20-3102(L).

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2404. Arbitrators

A. Contracted entities. The Department shall contract with one or more persons to provide Arbitrators. The Department must have a list of at least four Arbitrators to assign to Arbitrations. The Department shall publish the list of contracted entities and a list of each entity's qualified Arbitrators on its website.

B. Arbitrator Qualifications. Any person contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.

C. Alternative Arbitrators. A health insurer and provider may mutually agree to use an Alternative Arbitrator if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.

D. Appointment of an Arbitrator.
1. The Department shall appoint an Arbitrator for each Arbitration.
2. If the health insurer and health care provider do not agree to the Arbitrator appointed by the Department, they shall either:
   a. Mutually agree to use an Alternative Arbitrator; or
   b. Participate in the following procedure:
      i. The Department shall assign three Arbitrators.
      ii. The health insurer shall strike one Arbitrator.
      iii. The health care provider shall strike one Arbitrator.
      iv. If one Arbitrator remains, the Department shall appoint the remaining Arbitrator to the Arbitration.
      v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2405. Before the Arbitration

A. Enrollee's duties. Before the Arbitration, the enrollee shall:
1. Pay or make arrangements in writing to pay to the health care provider the amount stated by the health insurer in the Informal Settlement Teleconference which shall be the total amount of the enrollee's cost sharing requirements due for the health care services that are the subject of the qualifying surprise out-of-network bill.
2. Pay to the health care provider any amount that the enrollee has received from the health insurer as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

B. Health insurer's duties. Before the Arbitration, the health insurer shall remit any amount due to the health care provider if the health care insurer pays for out-of-network services directly to health care providers and the health insurer has not remitted any amounts due.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2406. The Arbitration

A. Conduct of Arbitration. An Arbitration of a qualifying out-of-network surprise bill shall be conducted:
1. Telephonically unless the parties agree otherwise;
2. With or without the enrollee's participation;
3. Within 120 days after the Department's Notice of Arbitration unless agreed otherwise by the parties; and
4. For a maximum duration of four hours unless agreed otherwise by the parties.

B. Arbitrator's Determination. The Arbitrator or Alternative Arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

C. Allowable Evidence. The Arbitrator or Alternative Arbitrator shall allow each party to provide relevant information for evaluating the qualifying surprise out-of-network bill including:
1. The average contracted amount that the health insurer pays for the health care services at issue in the county where the health care provider performed the health care services;
2. The average amount that the health care provider has contracted to accept for the health care services at issue in the county where the health care provider performed the services;
3. The amount Medicare and Medicaid pay for the health care services at issue;
4. The health care provider's direct pay rate for the health care services at issue, if any, under A.R.S. § 32-3216;
5. Any information that would be evaluated in determining whether a fee is reasonable under title 32 and not excessive for the health care services at issue, including the usual and customary charges for the health care services at issue performed by a health care provider in the same or similar specialty and provided in the same geographic area; and
6. Any other reliable sources of information, including databases, that provide the amount paid for the health care services at issue in the county where the health care provider performed the services.

D. Final Written Decision. Within 10 business days following the Arbitration, the Arbitrator or Alternative Arbitrator shall issue a Final Written Decision and provide a copy to the enrollee, the health insurer, the health care provider, the health care provider's billing company (if applicable) and the health care provider's authorized representative (if applicable).

E. Payment of the claim. The health insurer shall remit its portion of the payment awarded by the Arbitrator or Alternative Arbitrator to the health care provider within 30 days of the date of the Final Written Decision. A claim that is reprocessed by a health insurer as a result of the Arbitration is not in violation of A.R.S. § 20-3102(L).

F. Payment of the Costs of Arbitration. The health insurer and health care provider shall make payment arrangements with the Arbitrator or Alternative Arbitrator to pay their respective shares of the costs of the Arbitration within 30 days after the date of the Final Written Decision.The respective shares of the costs of Arbitration are determined as follows:
1. The enrollee is not responsible for any portion of the cost of the Arbitration.
2. The health insurer and the health care provider shall share the costs of the Arbitration equally unless one of the following exceptions applies:
   a. The health insurer and health care provider agree to share the costs of the Arbitration in non-equal portions.
   b. The health insurer pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.
   c. The health care provider or the health care provider's representative pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

G. Confidentiality. In connection with the Arbitration of a qualifying surprise out-of-network bill, all of the following apply:
1. All pricing information provided by a health insurer or health care provider is confidential.

2. Pricing information provided by a health insurer or health care provider may not be disclosed by the Arbitrator, Alternative Arbitrator or any other party participating in the Arbitration.
3. Pricing information provided by a health insurer or health care provider may not be used by anyone, except the party providing the information, for any purpose other than to resolve the qualifying surprise out-of-network bill.
4. All information received by the Department in connection with the Arbitration is confidential and may not be disclosed to any person except the Arbitrator or Alternative Arbitrator.

H. Arbitrator's Report. At the conclusion of each Arbitration, the Arbitrator shall produce a report to the Department that contains the following information:
1. Date of Arbitration;
2. Date the Arbitrator issued the Final Written Decision;
3. Whether the parties settled the qualifying surprise out-of-network bill during the Arbitration;
4. The initial amount billed by the health care provider;
5. The payment amount awarded to the health care provider; and
6. Any other information the Department may request an Arbitrator to report prior to an Arbitration.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).