CHAPTER 69

Department of Insurance

(Statutory Authority: 1976 Code §§ 1–23–10 et seq., 1–23–110 et seq., 34–29–10 et seq., 34–31–10 et seq., 37–4–101 et seq., 38–1–20(34), 38–3–60, 38–3–110 et seq., 38–5–80, 38–9–180, 38–23–10 et seq., 38–33–10 et seq., 38–33–200, 38–38–550, 38–39–10 et seq., 38–43–10 to 38–43–80, 38–43–100, 38–43–106, 38–43–110, 38–45–50, 38–47–10 et seq., 38–47–40, 38–49–10 et seq., 38–50–90, 38–55–50, 38–57–20 et seq., 38–63–10, 38–65–10, 38–69–10, 38–71–730, 38–73–330, 38–73–730, 38–73–735, 38–73–760, 38–77–530, 38–78–110 1975 Act No. 306)

69–1. Adjustment of Claims Under Unusual Circumstances.

(Statutory Authority: 1976 Code Sections 1–23–110 et seq., 38–3–110 et seq., and 38–49–20 et seq.)

1. Licensed Adjusters or motor vehicle physical damage appraisers in South Carolina are authorized to adjust claims or appraise automobiles under the physical damage insurance coverage for unlicensed companies under the following circumstances:

(a) Where the insured has an accident in South Carolina but is not a resident, being in a status of a transient.

(b) Where the insured is a new resident in the State and has an unexpired policy of an unlicensed company purchased before he moved into the State.

2. The law provides the conditions under which a Non-Resident Adjuster or motor vehicle physical damage appraiser may be licensed. In the event of a catastrophe where there are insufficient Licensed Adjusters or motor vehicle physical damage appraisers in South Carolina to handle claims expeditiously, Non-Resident Adjusters or motor vehicle physical damage appraisers will be permitted to enter the State to handle the adjustments arising out of the catastrophe without being required to be licensed in South Carolina, provided that the Adjuster or motor vehicle physical damage appraiser exhibits evidence of an Adjuster's or motor vehicle physical damage appraiser's License in his home state and remains in the State only for the period that is necessary to assist in the adjustments or appraisals.

3. An unusual circumstance or catastrophe exists when, due to a specific, infrequent, and sudden natural or manmade disaster or phenomenon, there have arisen losses to property in South Carolina that are covered by insurance, and the losses are so numerous and severe that resolution of claims related to such covered property losses will not occur expeditiously without the authorization of emergency adjusters or motor vehicle physical damage appraisers by the Department due to the magnitude of the catastrophic damage.

4. The Department will determine and announce when an emergency or catastrophe exists and also will determine and announce the expiration of the period of emergency or catastrophe.

HISTORY: Amended by State Register Volume 25, Issue No. 6, eff June 22, 2001; SCSR 42–5 Doc. No. 4803, eff May 25, 2018.

69–3. Definitions.

1. Except as may be otherwise set forth by the Statutes of this State, the following words and phrases, whenever and wherever they appear in matters under the cognizance of this Commission, shall have the meaning ascribed herein:

Accepting insurer—The Company that agrees to insure the risk.

Acquisition cost—That portion of premium, or part of a rate, representing the costs of securing lines of insurance.

Adjustor—A person who determines the extent of insured losses and assists in settling, or attempts to settle claims, usually representing the insurer.

Admitted assets—Those assets of an insurer which conform to the regulations of the South Carolina Insurance Commission.

Advisory organization—An organization that formulates policy and principles without the authority to apply them.

Affiliate—A corporation of which a majority of the capital stock is owned or controlled by any or all of the stockholders, directors or officers of another corporation, who also own or control a majority of the stock of such other corporation.

Agent—As defined in § 38-43-10 of the S. C. Code of Laws, 1976.

Alien insurer—An insurer formed under the laws of a country other than the United States of America, its States, Commonwealths, Territories or insular possessions.

All risks—A term commonly used in insurance to denote the coverage of damage or loss of property from all hazards except depreciation, deterioration and wear and tear.

Ancillary state—Any state other than a domiciliary state.

Appraisal—Estimate of value made by qualified, impartial and disinterested persons, duly appointed for such purpose.

Articles—Articles of incorporation and all amendments thereto.

Assessment—An apportionment or call made on the entire membership of a mutual company or association for definite contributions or payment of money on account of losses sustained by particular members.

Assigned risk—The protection of a specific insurance risk that has been directed to a given insurer by qualified authority.

Assuming insurer—The company, party to a reinsurance transaction, which assumes insurance, annuity and endowment risks.

Authorized insurer—An insurer duly licensed to do business in this State.

Average rate—A composite unit measuring the various perils of more than a single subject of insurance and usually at separate locations, expressed in dollars and cents per $100.00 of protection.

Basic rate—The foundation unit expressed in monetary amounts to which fractional amounts are added to accurately develop the correct final rate for the insurance exposure.

Blanket coverage—Insurance which contemplates that the risk is shifting, fluctuating or varying, and which covers a class of property or persons rather than any particular thing or persons.

Board of directors—Synonymous with board of trustees, and means the body having power and responsibility for the management and control of a corporation, fraternal benefit association or other association, by whatever name called, and the advisory body having similar powers in reference to a reciprocal insurer or Lloyds underwriters.

Broker—As defined in § 38-45-10, S. C. Code of Laws, 1976.

Brokerage—Any arrangement or agreement whereby any agent can be held to be the agent of the insured and not of the insurer, or whereby an agent is permitted to solicit or place any class of insurance other than those authorized to be issued in South Carolina by such agent's insurer.

Bureau—An organization designed to render specific services in regard to insurance.

Capital—The aggregate amount paid in on the shares of capital stock of a corporation issued and outstanding, and equal to the par or declared value of the stock issued.

Capital stock—The aggregate amount of the par or declared value of all shares of capital stock.

Ceding company—The Company, party to a reinsurance transaction, whose insurance, annuity and endowment risks or obligations are assumed.

Certificate of insurance—A memorandum copy, complete or abbreviated, of an insurance contract.

Charter—The basic instrument, by whatever name called, prescribing the powers, purposes and organization of a corporation.

Chief Insurance Commissioner—The chief officer of the Insurance Department, appointed by the Insurance Commission.

Co-insurance—A stipulation or requirement that the insured undertakes to be his own insurer to the extent that he fails to maintain insurance of a given percentage of the value of the property against loss or damage.

Commission—That part of the premium paid to the agent as compensation for his services.

Corporation—Except as otherwise indicated, "corporation" means a corporation formed or existing under the laws of this State.

Debit—A defined geographical area assigned to a particular agent, usually for the writing of industrial insurance.

Debit agent—One who collects weekly, bi-weekly or monthly premiums from a number of policyholders, generally small policies, in a designated territory, and generally industrial insurance.

Decreasing interest insurance—Same as decreasing balance insurance. Insurance written on a risk, generally in connection with a loan, wherein the coverage decreases commensurate with the decrease of obligation.

Department—The Insurance Department of this State; also, the Insurance Commission of this State.

Deputy—The first, or other deputy chief insurance commissioner of this State, so appointed by the Chief Insurance Commissioner.

Deviation—A departure, either in rate or coverage, from the prevailing standards.

Dividends—The excess of premiums collected, over costs of insurance, returned or credited to the policyholder.

Domestic insurer—An insurer formed under the laws of this State.

Domiciliary state—The State in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the State in which such insurer, having become authorized to do business in such State, has designated as its domiciliary State and/or State of entry into the United States.

Earned premium—That portion of the gross premium absorbed, at a given time, by costs of administration, risk, and profit.

Fire insurance and Allied lines—Insurance providing indemnity to the insured in case of loss or damage occasioned by fire and such other forms of property insurance as are undertaken by fire insurance companies in addition to marine and inland marine insurance.

Foreign domesticated insurer—A foreign insurer licensed to do business in this State.

Foreign insurer—An insurer, not an alien insurer, formed under laws other than the laws of this State.

Fraternal Benefit Association—As defined in § 38-37-10, S. C. Code of Laws, 1976.

General Assets—All property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons and as to such specifically encumbered property the term includes such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders, or all policyholders and creditors in the United States, shall be deemed general assets.

Gross Premium—The whole amount of the money consideration, given at fixed intervals during the lifetime of a policy of insurance, in exchange for the insurance set forth in the policy.

Group Insurance—A form of personal insurance which is issued to members of an organized body qualified, and not specifically prohibited, to be an insured, in which individual insurances are placed upon the persons of each member of that group, but in which the group acts as an entity in the payment of premiums, inception of the contract, and the like.

Holding company—Has the same meaning as parent corporation. (See "subsidiary".)

Incorporator—A person, natural or corporate, who signs the articles of incorporation.

Insurance—A contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.

a. Accident Insurance—Insurance against loss or damage due to unexpected injury to the person insured and resulting in disability or death.

b. Casualty Insurance—Those forms of indemnity providing for payment for loss or damage, resulting from accidental or some unanticipated contingency, except fire and the elements.

c. Credit Insurance—An indemnity to merchants or traders against the insolvency of customers to whom they extend credit and under the Small Loan Act, various insurances on the lives, property and health of borrowers to the extent of the amount loaned and unrepaid.

d. Fidelity Insurance—Insurance against loss from the want of honesty, integrity or fidelity of employees or others in a position of trust.

e. Fire Insurance—A contract of indemnity against loss by fire and lightning.

f. Group Insurance—See specific heading.

g. Health Insurance—A contract of indemnity against expense and loss of time resulting from disease.

h. Industrial Insurance—A plan of insurance under which policies of insurance are issued in consideration of weekly, bi-weekly or monthly payments.

i. Inland Marine Insurance—A contract of indemnity against loss suffered in connection with inland land or water transportation or with communications equipment.

j. Liability Insurance—Insurance against loss or liability on account of bodily or property injury sustained by others.

k. Life Insurance—A contract whereby in consideration of the payment of premiums the insurer engages to pay a certain sum upon the death of the insured.

l. Marine Insurance—A contract of indemnity against loss from marine perils.

m. Reciprocal Insurance—See specific heading.

n. Surety Insurance—An insurance contract whereby one, for a consideration, agrees to indemnify another against losses arising from the want of integrity, fidelity or solvency of employees and persons holding positions of trust, or against insolvency of losses from nonpayments of notes and other evidence of indebtedness, or against other breaches of contract. As generally used, this insurance is synonymous with guaranty insurance.

Insurance rate—The mathematical figure per $100 of insurance which determines the premium.

Insurer—Any legal entity, engaged or attempting to engage in the business of making insurance or surety contracts.

Level insurance—Insurance in which the amount of insurance benefit does not decrease during its term.

License—A certificate of authority, issued by a qualified public agency, to act within prescribed limits.

Lien-endorsement coverage—An endorsement added to an automobile physical damage policy indemnifying a lending agency against loss resulting from prior existing liens.

Lodge—As set forth in § 38-37-20, S. C. Code of Laws, 1976.

Member—One who holds a contract of insurance or is insured in an insurance company other than a stock corporation.

Minimum surplus—The minimum amount by which the admitted assets of an insurer, over and above the capital stock, must exceed its liabilities, in order to be licensed to do business in this State.

Multiple line insurance—A policy of insurance insuring more than one class of risk.

Net premium—That portion of the gross premium remaining after adjustments of debits, credits and dividends.

Non-Recording insurance—An insurance contract protecting a lender from loss occasioned by his failure to record a mortgage given as security for the loan made.

Officer—Any person charged with active management and control, in an executive capacity, of the affairs of a corporation.

Parent corporation—See "subsidiary".

Person—Any legal entity.

Policy—A contract of insurance.

Policyholder—Holder of a contract of insurance.

Preferred claim—Any claim with respect to which the law of a State or of the United States accords priority of payment from the general assets of the insurer.

Premium—Money or any other thing of value paid or given in consideration of a contract of insurance.

Premium reserves—A fund set aside for the payment of future benefits under a policy.

Reciprocal insurance exchange—A group or association of persons cooperating through an attorney-in-fact for the purpose of insuring themselves and each other.

Reinsurance—The assumption of a portion of the risk on a policy by another insurer.

Renewal license—A license which becomes effective immediately following the termination of a license previously issued and in force, and which differs from such previous license only in respect to the date of expiration.

Return premium—Return to the policyholder of the unearned portion of a premium upon cancellation, or adjustment in rate, of a policy.

Shareholder—A holder of record of shares of stock in a corporation.

Short rate—A penalty rate, using percentages slightly higher than would result from pro-rata calculations.

Single interest insurance—Insurance in which the benefit amount decreases during its term in accordance with predetermined scale.

Specific insurance—A contract of insurance which definitively describes the thing insured and the amount of insurance applying thereto.

Subsidiary—A corporation of which the majority of the capital stock is owned or controlled by another corporation, called the "parent corporation".

Surplus to policyholders—The excess of total admitted assets over the liabilities of an insurer which shall be the sum of all capital and surplus accounts minus any impairment thereof.

Unauthorized insurer—Any insurer not authorized to do business in this State.

Unearned premium—That portion of the gross premium, at a given time, that is unearned or unexhausted by the earned premium.

Unearned premium reserve—Funds, equal to the unearned premium, set aside for contingencies.

69–4. Life, Accident and Health Insurance—Reserve Tabulations.

Each and every domestic insurance company having life and/or accident and health insurance in force shall submit, with the annual statement required by this Department, a copy of the valuation tabulation used in the determination of its reported life and accident and health reserve. If the tabulation is a summarization, each company shall be prepared to support each and every phase of the summary by detailed cards, listings, or some form of acceptable running inventory. This detailed information shall be maintained until verification of the valuation has been made by a representative or representatives of this Department.

Each company shall take the necessary steps to acquire and maintain, in its home office, the necessary reserve tables for proper calculation of reserves on all contracts in force as of the applicable valuation date. If the insurance is of such a nature that no appropriate mortality or morbidity tables have been published, the company may use methods and approximations warranted by company experience and approved by the Chief Insurance Commissioner.

69–5. Policy Approvals.

On January 1, 1962, and thereafter, every industrial life insurance policy or contract submitted to this Department for approval by a domestic insurance company, must be accompanied by the appropriate net premium and terminal reserve, except in those instances where the applicable net premiums and terminal reserves have been published.

Every ordinary life policy or contract must be accompanied by the appropriate net premium, terminal and mean reserves, except in those instances when such premiums and reserves have been otherwise published.

If such premiums and reserves are not submitted because of publication, the name of the publication together with a statement that the company possesses and maintains a copy of the publication must be submitted in writing to this Department.

No approval of any industrial life policy or contract or any ordinary life policy or contract will be given except upon compliance with this Regulation.

69–5.1. Minimum Standards for the Readability of Commonly Purchased Insurance Policies.

A. Purpose: The purpose of this Regulation is to establish minimum standards of readability applicable to all commonly purchased personal policies, contracts and certificates of insurance delivered or issued for delivery in this State.

This Regulation is not intended to increase the risk assumed by insurance companies or other entities subject to this Act or to supersede their obligation to comply with the substance of other insurance legislation applicable to such forms of insurance policies. This Regulation is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

A policy is a legal document. Revision of the policy to make it more readable must not lead to its devaluation as a legal document. The policy must comply with all statutory and regulatory requirements.

B. Definitions—As used in this Regulation:

(1) "Director" is as defined in Section 38–1–20.

(2) "Policy" or "Policy Forms" means any policy, certificate, rider, amendment, endorsement, contract, plan or agreement of personal insurance, and any renewal thereof including homeowners, dwelling fire, automobile, accident and health, life and all other forms of personal insurance delivered or issued for delivery in this State by any company subject to this Regulation; any certificate, contract or policy issued by a fraternal benefit society, and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this State. The Director may add other policies as he deems advisable.

(3) "Company" or "Insurer" means any life and health, accident, property and casualty, title or marine insurance company, reciprocal, county mutuals, fraternal benefit society, nonprofit health services corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations.

C. Applicability:

This Regulation shall apply to all policies delivered or issued for delivery in this State by any insurer on or after the date such forms must be approved under this Regulation, but nothing in this Regulation shall apply to:

(1) Any policy which is a security subject to federal jurisdiction;

(2) Any group policy; however, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this State or mass marketed certificates subject to approval by this Department;

(3) Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;

(4) Commercial, fleet vehicle and incidental personal coverages which are a part of a commercial policy;

(5) Any life, accident and health form used in connection with, as a conversion from, as an addition to, in exchange for, or issued pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the date such forms must be approved under this Regulation;

(6) Renewal of a life or accident and health policy delivered or issued for delivery prior to the date such forms must be approved under this Regulation;

(7) Surety or fidelity bonds.

D. Minimum Policy Readability Standards:

(1) In addition to any other requirements of law, no policy forms of personal insurance except as stated in Section C, shall be delivered or issued for delivery in this State on or after the dates such forms must be approved under this Regulation 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) of this Section;

(b) It is printed, except for specification pages, schedules and tables, in not less than ten point type, one point leaded;

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or riders; and

(d) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words or if the policy is printed on more than three pages.

(2) For the purposes of this Section, a Flesch Reading Ease Test Score shall be measured by the following method:

(a) For a policy containing 10,000 words or less of text, the entire policy shall be analyzed. For a policy containing more than 10,000 words, the readability of two 100-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(c) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(d) The sum of the figures computed under (b) and (c) subtracted from 206.835 equals the Flesch Reading Ease Test Score for the policy form.

(e) For purposes of this Section, the following procedures shall be used:

(1) A contraction, hyphenated word, numbers and letters when separated by spaces shall be counted as one word;

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions shall be counted as a sentence;

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) The term "text" as used in this Section shall include all printed matter except the following:

(1) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and sub-captions; specification pages, schedules or tables;

(2) Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the insurer identifies the language or terminology excepted by this 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 Ease Test if it is comparable in result to the Flesch Reading Ease Test.

(4) Any non-English language policy delivered or issued for delivery in this State shall be deemed to be in compliance with Section D(1) of this Regulation if the insurer certifies that the policy is translated from an English language policy which complies with Section D(1) of this Regulation.

(5) Filings subject to this Section shall provide the actual score or be accompanied by a certification signed by an officer of the insurer or filing organization stating that the policy form meets the minimum requirements of Section D(1). Such certification shall state that the policy form meets the minimum reading ease test score on the test used or that the score is lower than the minimum required but should be approved in accordance with Section E. To confirm the accuracy of any certification or score, the Director may require the submission of further information to verify the certification or score in question. If it is necessary to alter coverage, such change must be noted and explained upon submission for filing.

(6) At the option of the insurer, riders, endorsements, 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.

E. Powers of the Director: The Director may approve a policy which does not meet the minimum Flesch Reading Ease Test Score required herein whenever, in his sole discretion, he finds such approval:

(1) will provide a more accurate reflection of the readability of a policy form;

(2) is warranted by the nature of a particular policy, or

(3) is warranted by certain policy language which is drafted to conform to the requirements of any State law, regulation or agency interpretation.

F. Approval of Forms: A policy meeting the requirements of Section D(1) shall be approved, notwithstanding the provisions of any other law which specify the content of policies, if the policy provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

G. Effective Dates:

This regulation, as amended, becomes effective upon publication in the State Register.

H. Penalties: Any insurer who violates the provisions of this regulation shall be subject to the penalties set forth in Section 38–2–10 of the Code of Laws of South Carolina 1976, as amended.

HISTORY: Added by State Register Volume 3, eff July 13, 1979. Amended by SCSR 44–6 Doc. No. 4931, eff June 26, 2020.

69–6. Brokers' Licenses.

1. No person shall be licensed as an insurance broker to represent citizens of this State for the placing of insurance unless such person, at the time the initial or renewal application is made for an insurance broker's license, possesses a valid, current insurance agent's license for that line of business for which the brokerage authority is intended to apply, and has been so licensed as such an insurance agent for not less than two (2) years.

2. Every broker's license issued shall be restricted to those lines of business for which specific application is made and must be supported by record of prior issuance of agent's license for such lines of business. The limits of authority of all broker's licenses shall be plainly set forth on the face of the license.

69–7. Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts.

SECTION I. Introduction.

A. Scope.

1. These standards apply to all individual and group accident and health insurance coverages except credit insurance.

2. When an insurer determines that adequacy of its accident and health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

3. With respect to any block of contracts, or with respect to an insurer's accident and health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

4. Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's accident and health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium, and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

5. Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

B. Categories of Reserves.

1. The following sections set forth minimum standards for three categories of accident and health insurance reserves:

a. Section II. Claim Reserves.

b. Section III. Premium Reserves.

c. Section IV. Contract Reserves.

2. Adequacy of an insurer's accident and health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

C. Appendices.

1. These standards contain two appendices which are an integral part of the standards, and one additional "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

2. Appendix A. Specific minimum standards with respect to morbidity, mortality, and interest, which apply to claim reserves according to year of incurral and to contract reserves according to year of issue.

3. Appendix B. Glossary of Technical Terms Used.

4. Appendix C. (Supplementary) Waiver of Premium Reserves.

SECTION II. Claim Reserves.

A. General.

1. Claim reserves are required for all incurred but unpaid claims on all accident and health insurance policies.

2. Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

3. All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

B. Minimum Standards for Claim Reserves.

1. Disability Income.

a. Interest. The maximum interest rate for claim reserves is specified in Appendix A.

b. Morbidity. Minimum standards with respect to morbidity are those specified in Appendix A; except that, at the option of the insurer: (i) For claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities. (ii) For group disability income claims with a duration from the date of disablement of more than two years but less than five years, reserves may, with the approval of the Director of Insurance, be based upon the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(I) An analysis of the credibility of the experience;

(II) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(III) A description and quantification of the margins to be included;

(IV) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(V) A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(VI) Any other information deemed necessary by the Director of Insurance.

DRAFTING NOTE: For experience to be considered credible for purposes of (ii), the company should be able to provide claim termination patterns over no more than six (6) years reflecting at least 5,000 claim terminations during the third through fifth claim durations on reasonably similar applicable policy forms.

For claim reserves to reflect "sound values" and/or reasonable margins, reserve tables based on credible experience should be adjusted regularly to maintain reasonable margins. Demonstrations may be required by the commissioner of the state of domicile based on published literature (e.g. Goldman, TSA XLII).

c. Duration of Disablement. For contracts with an elimination period, the duration of disablement should be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

2. All Other Benefits.

a. Interest. The maximum interest rate for claim reserves is specified in Appendix A.

b. Morbidity or Other Contingency. The reserve should be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

C. Claim Reserve Methods Generally.

1. Any generally accepted or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities.

2. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

SECTION III. Premium Reserves.

A. General.

1. Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

2. If premiums due and unpaid are carried as an asset, such premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.

3. The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the

valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

B. Minimum Standards for Unearned Premium Reserves.

1. The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

a. The valuation net modal premium on the contract reserve basis applying to the contract; or

b. The gross modal premium for the contract if no contract reserve applies.

2. However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve to the extent not provided for elsewhere.

C. Premium Reserve Methods Generally.

1. The insurer may employ suitable approximations and estimates including, but not limited to groupings, averages, and aggregate estimation, in computing premium reserves.

2. Such approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

SECTION IV. Contract Reserves.

A. General.

1. Contract reserves are required, unless otherwise specified in Section IV.A.2. for:

a. all individual and group contracts with which level premiums are used; or

b. all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The values specified in this subparagraph b. shall be determined on the basis specified in Section IV.B.

2. Contracts not requiring a contract reserve are:

a. contracts which cannot be continued after one year from issue; or

b. contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

3. The contract reserve is in addition to claim reserves and premium reserves.

4. The methods and procedures for contract reserves should be consistent with those for claim reserves for any contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

B. Minimum Standards for Contract Reserves—Basis.

1. Morbidity or Other Contingency.

a. Minimum standards with respect to morbidity are those set forth in Appendix A. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration, and period for which gross premiums have been calculated.

b. Contracts for which tabular morbidity standards are not specified in Appendix A shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the Director of Insurance.

2. Interest. The maximum interest rate is specified in Appendix A.

3. Termination Rates.

a. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A. except as noted in the following paragraph.

b. Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(1) Eighty percent of the total termination rate used in the calculation of the gross premiums, or

(2) Eight percent.

c. Where a morbidity standard specified in Appendix A is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the Director of Insurance.

4. Reserve Method.

a. For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

b. For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(1) For individual policies and group certificates issued on or before December 31, 1997, reserves calculated on the two-year full preliminary term method.

(2) For individual policies and group certificates issued on or after January 1, 1998, reserves calculated on the one-year full preliminary term method.

c. For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(1) On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary.

(2) On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

d. The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

5. Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

C. Alternative Valuation Methods and Assumptions Generally.

1. Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above, an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency.

2. Also, subject to the preceding condition, the insurer may employ methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following:

a. The net level premium method;

b. The one-year full preliminary term method;

c. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

d. The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;

e. The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and

f. The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

D. Tests for Adequacy and Reasonableness of Contract Reserves.

1. Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of Section IV.B.

2. In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

SECTION V. Reinsurance.

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

SECTION VI. Appendix A. Specific Standards for Morbidity, Interest and Mortality.

A. Morbidity.

1. Minimum morbidity standards for valuation of specified individual contract accident and health insurance benefits are as follows:

a. Disability Income Benefits Due to Accident or Sickness.

(1) Contract Reserves:

(a) Contracts issued on or after January 1, 1963, and prior to January 1, 1968: Conference Modification of Class III Disability Table.

(b) Contracts issued on or after January 1, 1968, and prior to January 1, 1990: The 1964 Commissioners Disability Table (64 CDT).

(c) Contracts issued on or after January 1, 1992: The 1985 Commissioners Individual Disability Tables A (85CIDA); or the 1985 Commissioners Individual Disability Tables B (85CIDB).

(1) Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard.

(2) The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(d) Contracts issued during 1990 or 1991: Optional use of either the 1964 Table or the 1985 Tables.

(2) Claim Reserves: The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

b. Hospital Benefits, Surgical Benefits, and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

(1) Contract Reserves:

(a) Contracts issued on or after January 1, 1963, and before January 1, 1990: The1956 Intercompany Hospital-Surgical Tables.

(b) Contracts issued on or after January 1, 1992: The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, page 63. Refer to the paper (in the same volume, page 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(c) Contracts issued during 1990 or 1991: Optional use of either the 1956 Tables or the 1974 Tables.

(2) Claim Reserves: No specific standard. See Section VI.A.1.e.

c. Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

(1) Contract Reserves: Contracts issued on or after January 1, 1992: The 1985 NAIC Cancer Claim Cost Tables.

(2) Claim Reserves: No specific standard. See Section VI.A.1.e.

d. Accidental Death Benefits.

(1) Contract Reserves: Contracts issued on or after January 1, 1968: The 1959 Accidental Death Benefits Table.

(2) Claim Reserves: Actual amount incurred.

e. Other Individual Contract Benefits.

(1) Contract Reserves: For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(2) Claim Reserves: For all benefits other than disability, claim reserves are to be determined as provided in the standards.

2. Minimum morbidity standards for valuation of specified group contract accident and health insurance benefits are as follows:

a. Disability Income Benefits Due to Accident or Sickness.

(1) Contract Reserves:

(a) Contracts issued prior to January 1, 1992: The same basis, if any, as that employed by the insurer as of January 1, 1992;

(b) Contracts issued on or after January 1, 1992: The 1987 Commissioners Group Disability Income Table (87CGDT).

(2) Claim Reserves:

(a) For claims incurred on or after January 1, 1992: The 1987 Commissioners Group Disability Income Table (87CGDT);

(b) For claims incurred prior to January 1, 1992: Use of the 87CGDT is optional.

b. Other Group Contract Benefits.

(1) Contract Reserves: For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(2) Claim Reserves: For all benefits other than disability, claim reserves are to be determined as provided in the standards.

B. Interest.

1. For contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the accident and health insurance contract.

2. For claim reserves, on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

3. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurred date, reduced by one hundred basis points.

C. Mortality.

1. Except as provided in subsection 2, the mortality basis used shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the accident and health insurance contract.

2. Other mortality tables adopted by the NAIC and promulgated by the Director of Insurance may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the Director of Insurance. The request for such approval must include the

proposed mortality table and the reason that the standard specified in Subsection 1 is inappropriate.

SECTION VII. Appendix B. Glossary of Technical Terms Used.

A. Annual-Claim Cost. The net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

B. Claims Accrued. That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

C. Claims Reported. When an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

D. Claims Unaccrued. That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

E. Claims Unreported. When an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

F. Date of Disablement. The earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally, this date will coincide with the start of any elimination period.

G. Elimination Period. A specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

H. Gross Premium. The amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit, or contingencies.

I. Level Premium. A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed, in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it is based are revised at a later time.

1. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years.

2. The building of a prospective contract reserve is a natural result of level premiums.

J. Long-Term Care Insurance. Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; 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 term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss

of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

K. Modal Premium. This refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus, if the annual premium is $100 and if, instead, monthly premiums of $9 are paid, then the modal premium is $9.

L. Negative Reserve. Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

M. Preliminary Term Reserve Method. Under this method of valuation, the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

N. Present Value of Amounts Not Yet Due on Claims. The reserve for "claims unaccrued" (see definition), which may be discounted at interest.

O. Reserve. The term "reserve" is used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

1. An insurer under its contracts promises benefits which result in claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

2. An insurer under its contracts promises benefits which result in claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

P. Terminal Reserve. This is the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

Q. Unearned Premium Reserve. This reserve values that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

R. Valuation Net Modal Premium. This is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus, if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

SECTION VIII. Appendix C. Reserve for Waiver of Premium—(Supplementary explanatory material).

A. Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

B. Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

1. Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

2. Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

3. Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

C. If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

HISTORY: Amended by State Register Volume 15, Issue No. 3, eff March 22, 1991; State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

69–8. Reserves for Mortgage Guaranty Insurance.

This Regulation shall apply to all insurers writing mortgage guaranty insurance in South Carolina. Mortgage guaranty insurance is defined for the purposes of this Regulation as the insurance of mortgage lenders against loss by reason of nonpayment of mortgage indebtedness by borrowers, and should not be confused with other kinds of insurance written incidental to mortgage loan transactions such as mortgage redemption life insurance, hazard insurance covering improvements to real property, and credit accident and health coverages.

1. Unearned premium reserves for mortgage guaranty insurance shall be computed in accordance with §§ 38-5-60, 38-9-170 and 38-9-180 which specify that such reserves are to be computed by the use of annual or more frequent pro rata fractions.

2. In addition to the unearned premium reserve, every mortgage guaranty insurer writing business in this State must establish and maintain a contingency reserve, computed as hereinafter described, for the further protection of such companies and their policyholders against the adverse effects of economic cycles and other causes of excessive loss experience. The contingency reserve shall be credited not less frequently than annually, as of the end of each calendar year, with an amount equal to fifty per cent of the premiums earned during the year, computed in accordance with §§ 38-5-60, 38-9-170 and 38-9-180. Each such amount credited to the contingency reserve shall be carried as a liability for fifteen years following the year for which the credit is established, unless used to pay mortgage guaranty losses as hereinafter provided.

3. If for any year the incurred losses and loss expenses for mortgage guaranty insurance shall exceed forty per cent of the premiums earned on such business, the contingency reserve may be charged with the amount of such excess if such charge is approved by the Chief Insurance Commissioner. Any such annual charges shall be treated so as to reduce or remove the amounts originally credited to said reserve on a first-in, first-out basis.

4. Annual statements reflecting mortgage guaranty insurance transactions by licensed insurers must be prepared in compliance with this Regulation to meet the requirements of § 38-13-100.

69–9. Proxies, Consents and Authorizations of Domestic Insurers.

Effective Date: The following regulation shall be effective on and after April 1, 1966.

Section 1. Application of Regulation— This regulation is applicable to all domestic insurers having one hundred or more stockholders; provided, however, that this regulation shall not apply to any insurer if ninety-five per cent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than five hundred stockholders. A domestic insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities and Exchange Act of

nineteen hundred thirty-four and the Securities and Exchange Acts Amendments of nineteen hundred sixty-four and Regulation X-14 of the Securities and Exchange Commission promulgated thereunder shall be exempt from the provisions of this regulation.

Section 2. Proxies, Consents and Authorizations— any director, officer or employee of such insurer subject to Section 1 hereof, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect of any stock of such insurer in contravention of this regulation and Schedules A and B hereto annexed and hereby made a part of this regulation.

Section 3. Disclosure of Equivalent Information— or authorizations in respect of a stock of a domestic insurer subject to Section 1 hereof are solicited by or on behalf of the management of such insurer from the holders of record of stock of such insurer in accordance with this regulation and the Schedules thereunder prior to any annual or other meeting, such insurer shall, in accordance with this regulation and/or such further regulations as the Commissioner may adopt, file with the Commissioner and transmit to all stockholders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

Section 4. Definitions.

1. The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, shall be applicable for purposes of this regulation.

2. The terms "solicit" and "solicitation" for purposes of this regulation shall include:

(a) any request for a proxy, whether or not accompanied by or included in a form of proxy; or

(b) any request to execute or not to execute, or to revoke, a proxy; or

(c) the furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

3. The terms "solicit" and "solicitation" shall not include:

(a) any solicitation by a person in respect of stock of which he is the beneficial owner;

(b) action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

(c) the furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

Section 5. Information to Be Furnished to Stockholders.

1. No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

2. If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to Subsection 1 hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

3. Two copies of each report sent to the stockholders pursuant to this Section shall be mailed to the Commissioner not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to Subsection 1 of Section 7, whichever date is later.

Section 6. Requirements as to Proxy.

1. The form of proxy (a) shall indicate in bold face type whether or not the proxy is solicited on behalf of the management, (b) shall provide a specifically designated blank space for dating the proxy and (c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management or stockholders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to Subsection 3 hereof.

2. Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in bold face type how it is intended to vote the shares or authorization represented by the proxy in each such case.

3. A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

4. No proxy shall confer authority (a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

5. The proxy statement or form of proxy shall provide, subject to reasonable, specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to Subsection 2 hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

6. The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented.

Section 7. Material Required to Be Filed.

1. Two preliminary copies of the proxy statement and form of proxy and other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the Commissioner at least ten days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the Commissioner may authorize upon a showing of good cause therefor.

2. Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the Commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the Commissioner may authorize upon a showing of good cause therefor.

3. Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the Commissioner not later than the date such material is first sent or given to the stockholders.

4. Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes and shall be so filed with the Commissioner as herein provided.

5. Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this Section.

6. Notwithstanding the provisions of Subsections 1 and 2 hereof and of Subsection 5 of Section 10, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by Subsection 3 hereof not later than the date such material is used or published. The provisions of

Subsections 1 and 2 hereof and Subsection 5 of Section 10 shall apply, however, to any reprints or reproductions of all or any part of such material.

Section 8. False or Misleading Statements—No solicitation subject to this regulation shall be made by means of any proxy statement, form of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading.

Section 9. Prohibition of Certain Solicitations—No person making a solicitation which is subject to this regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

Section 10. Special Provisions Applicable to Election Contests.

1. **Applicability—**This Section shall apply to any solicitation subject to this regulation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

2. **Participant or Participant in a Solicitation**

(a) For purposes of this Section, the term "participant" and "participant in a solicitation" include: (i) the insurer; (ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (iii) any other person, acting alone or with one or more other persons, committees or groups in organizing, directing or financing the solicitation.

(b) For the purpose of this Section, the terms "participant" and "participant in a solicitation" do not include: (i) a bank, broker, or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant; (ii) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties; (iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment; (iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (v) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

3. **Filing of Information Required by Schedule B.**

(a) No solicitation subject to this Section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor, there has been filed with the Commissioner, by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments have been received and complied with, or until fifteen days have elapsed whichever shall first occur.

(b) Within five business days after a solicitation subject to this Section is made by the management of an insurer, or such longer period as the Commissioner may authorize upon a showing of good cause therefor, there shall be filed with the Commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this Section in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the Commissioner by or on behalf of each participant in such prior

solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this Subsection, additional persons become participants in a solicitation subject to this rule, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the Department may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the Commissioner.

4. **Solicitations Prior to Furnishing Required Written Proxy Statement—**Notwithstanding the provisions of Subsection 1 of Section 5, a solicitation subject to this Section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that:

(a) The statements required by Subsection 3 hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by Subsection 1 of Section 5 is furnished to such persons; provided, however, that this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by Subsection 3 hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

5. **Solicitations Prior to Furnishing Required Written Proxy Statement—Filing Requirements—**Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by Subsection 1 of Section 5 shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor.

6. **Application of This Section to Report—**Notwithstanding the provisions of Subsections 2 and 3 of Section 5, two copies of any portion of the report referred to in Subsection 2 of Section 5 which comments upon or refers to any solicitation subject to this Section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

Schedule A

Information Required in Proxy Statement

Item 1 Revocability of Proxy—State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2 Dissenters' Right of Appraisal—Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3 Persons Making Solicitations Not Subject to Section 10

1. If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

2. If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

3. If the solicitation is to be made by specially engaged employees or paid solicitors, state (a) the material features of any contract or arrangement for such solicitation and identify the parties, and (b) the cost or anticipated cost thereof.

Item 4 Interest of Certain Persons in Matters to Be Acted Upon—Describe briefly any substantial interest, direct or indirect, by stockholders or otherwise, of any director, nominee for election for director, officer, and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

Item 5 Stocks and Principal Stockholders

1. State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

2. Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, indicate the conditions under which other stockholders may be entitled to vote.

3. If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6 Nominees and Directors—If action is to be taken with respect to the election of directors, furnish the following information in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting:

1. Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

2. State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this regulation.

3. If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

4. State, as of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks, make a statement to that effect.

Item 7 Remuneration and Other Transactions With Management and Others—Furnish the information reported or required in Item 1 of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to (a) the election of directors, (b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (c) any pension or retirement plan in which any such person will participate, or (d) the granting or extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro-rata basis. If the solicitation is made on behalf of persons other than

the management, information shall be furnished only as to Item 1A of the aforesaid heading of Schedule SIS.

Item 8 Bonus, Profit Sharing and Other Remuneration Plans—If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, of the insurer furnish the following information:

1. A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

2. The amounts which would have been distributable under the plan during the last calendar year to (a) each person named in Item 7 of this schedule, (b) directors and officers as a group, and (c) all other employees as a group, if the plan had been in effect.

3. If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph 2 of this item, the nature of such amendments should be specified.

Item 9 Pension and Retirement Plans—If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

1. A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

2. State (a) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (b) the estimated annual payment to be made with respect to current services; and (c) the amount of such annual payments to be made for the benefit of (i) each person named in Item 7 of this schedule, (ii) directors and officers as a group, and (iii) employees as a group.

3. If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in sub-paragraph 2(c) of this item, the nature of such amendments should be specified.

Item 10 Options, Warrants, or Rights—If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro-rata basis, furnish the following information:

1. The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

2. If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following persons, naming each such person:

(a) each person named in Item 7 of this schedule, and

(b) each other person who will be entitled to acquire five per cent or more of the stock called for or to be called for by such warrants.

3. If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11 Authorization or Issuance of Stock

1. If action is to be taken with respect to the authorization or issuance of any stock of the insurer, furnish the title, amount and description of the stock to be authorized or issued.

2. If the shares of stock are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation,

preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

3. If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual report.

Item 12 Mergers, Consolidations, Acquisitions and Similar Matters

1. If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

2. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earning per share after related taxes and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13 Restatement of Accounts—If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

1. State the nature of the restatement and the date as of which it is to be effective.

2. Outline briefly the reasons for the restatement and for the selection of the particular effective date.

3. State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14 Matters Not Required to Be Submitted—If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15 Amendment of Charter, By-Laws, or Other Documents—If action is to be taken with respect to any amendment of the insurer's charter, by-laws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

Schedule B

Information to be Included in Statements Filed By or on Behalf of a Participant (Other Than the Insurer) in a Proxy Solicitation in an Election Contest

Item 1 Insurer—State the name and address of the insurer.

Item 2 Identity and Background

1. State the following:

(a) Your name and business address;

(b) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

2. State the following:

(a) Your residence address;

(b) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

3. State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

4. State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.

Item 3 Interest in Stock of the Insurer

1. State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

2. State the amount of each class of stock of the insurer which you own of record but not beneficially.

3. State with respect to the stock specified in 1 and 2 the amounts acquired within the past two years, the dates of acquisition and the amounts acquired on each date.

4. If any part of the purchase price or market value of any of the stock specified in paragraph 3 is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction and state the names of the parties.

5. State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.

6. State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

7. State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4 Further Matters

1. Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

2. Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

3. State whether or not you or any of your associates have any arrangement or understanding with any person

(a) with respect to any future employment by the insurer or its subsidiaries or affiliates; or

(b) with respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereto.

Item 5 Signature—The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct to the best of my knowledge and belief.

_____	_____
Date	Signature of participant or authorized representative

69–10. Premium Service Companies.

1. Every premium service agreement which confers upon a premium service company authority to cause a policy of insurance covering lives, property or interests situate in South Carolina to be terminated shall be deemed made in South Carolina and such policy shall be so terminated only in accordance with the provisions of Chapter 39 of Title 38, Code of Laws of South Carolina, 1976, and the Regulations pursuant thereto.

2. The provisions of this Regulation do not apply to premiums financed under revolving charge account arrangements by a licensee which is a subsidiary of an insurer or group of affiliated insurers where maximum charges do not exceed 7% per annum on the amount actually financed. Such revolving charge account arrangements shall be submitted to the Commissioner for approval or disapproval by specific order for each such arrangement.

3. No licensee nor other person acting for or in behalf of the licensee shall retain the original policy in connection with any premium service agreement, and any such retention of the original contract shall be deemed cause for the revocation of, or refusal to renew, the license of such licensee.

4. Every application for a license or renewal of the license as a premium service company shall be made on the form prescribed by the Chief Insurance Commissioner which shall be completed and filed in accordance with the instructions of the Commissioner accompanied by all required supporting documents and the applicable fee.

5. In the case of an original application for a license, the application shall be signed by:

(a) The sole proprietor, if the applicant is a sole proprietor; or

(b) A general partner, if the applicant is a partnership;

(c) The chief executive officer and the secretary if the applicant is a corporation or other business entity whose ownership is manifested by shares. Such original application shall be accompanied by the certified resolution of the board of directors or similar governing body of the corporation or other entity.

6. In the case of the renewal of an existing license or a change in such license, reference may be made to the earlier application and only those sections of the application form where changes are necessary need be completed, provided the signators to the original application certify under the pains and penalties of perjury that no change has occurred which would require an answer differing from that contained in the original application.

7. Licenses hereunder are hereby declared personal and issued by reason of special confidence in the licensee so licensed. No license may be transferred, directly or indirectly, nor shall such license be used for, or in behalf of, any person, firm or corporation whatsoever other than the licensee. Any such transfer, attempted transfer or use shall be void and shall be deemed sufficient grounds for the revocation of, or refusal to renew, the license.

8. Every corporation, or similar business entity, partnership, or proprietor doing business under a name, other than his or its own, shall file, and keep on file, with the Commissioner, the names and addresses of officers, directors, partners and proprietors and shall designate therein the name and address of the person upon whom service of process may be made.

9. No foreign corporation or similar business entity shall be licensed as a premium service company unless it shall first become domesticated in South Carolina. Certification of such domestication by the Secretary of State of South Carolina shall accompany the application of each such foreign corporation or similar business entity.

10. Transfer or assignment to another, or a series of transfers or assignments within a 6 month period, of 10% or more of the premium service agreements of a licensee shall be deemed a bulk transfer or assignment. No licensee shall effect a bulk transfer or assignment of premium service agreements unless it shall first file the proposed agreement with, and secure the approval of, the

Commissioner who shall grant such approval only if he is satisfied that such arrangements are just and equitable, that provision has been made for adequate notice to the insureds and insurers, that all funds due or payable to insureds and insurers have been paid or adequately secured, that the transferee or assignee has expressly assumed the obligations of the transferor or assignor arising out of such premium service agreements and/or that the transferor or assignor has provided indemnity or security with respect to such obligations.

11. Death of a proprietor shall terminate the license. Death or withdrawal of a partner shall suspend the license if the licensee is a partnership; provided, however, that if notice of such death or withdrawal is furnished to the Commissioner within 10 days of the event and the Commissioner is satisfied, by examination or otherwise, that the interests of insureds and insurers have been adequately protected, he may reinstate the suspended license.

Appointment of referee, receiver or trustee incident to bankruptcy or insolvency proceedings against the licensee shall suspend the license which may be reinstated only if the Commissioner finds that such proceedings have terminated and that the interests of insureds and insurers have been adequately protected.

12. The Commissioner shall be notified by registered or certified mail not later than 10 days after the event upon the occurrence of any of the following:

(a) When a partner dies or withdraws from a partnership which is a licensee, or when a new partner is admitted.

(b) When an officer, director or person owning or controlling 10% or more of the stock of a corporation or similar business entity, which is a licensee, ceases to be such, or, when a person becomes an officer, director or person owning or controlling 10% or more of the stock of such licensee.

(c) When any licensee, or any person who is a partner, officer, director or who owns 10% or more of the shares of the licensee is arrested, indicted or convicted with respect to any State or Federal offense involving moral turpitude other than a misdemeanor resulting from the operation of a motor vehicle.

(d) When a licensee suffers a revocation or suspension of license or is refused a license as a premium service company, premium finance company, insurance agency, or agent, in any other jurisdiction.

(e) When a voluntary or involuntary petition of bankruptcy or prayer for the appointment of a receiver or trustee is filed against the licensee or when the licensee enters into any assignment for the benefit of creditors or composition among creditors.

In the event of any of the foregoing, the Commissioner may conduct such examination and investigation as he deems necessary or appropriate for the protection of insureds and insurers, the expense of which shall be borne by the licensee. Without limitation upon the generality, he may require any of the affected persons to respond to interrogatories under oath or appear before him to testify under oath and may require such other or further disclosure as he deems necessary or appropriate.

13. Every premium service company shall, prior to their use, file the following forms with the Commissioner and receive his written approval:

(a) Insurance premium service agreement.

(b) Payment book.

(c) Notice of overdue payment.

(d) Request for cancellation.

(e) Notice to insurer that premium is financed under premium service agreement.

(f) Such other forms, other than advertising material and rate charts, as the licensee prepares or uses for delivery or mailing to insureds, insurers or insurance agents. This section does not apply to individual correspondence.

14. Forms filed with the Commission for approval shall be so filed in duplicate, one copy of which will be returned to the licensee endorsed with the approval or disapproval of the Commissioner.

15. No form, the filing of which is required hereunder, shall be used prior to its approval, and use of any such form which has not been approved, or which has been disapproved, shall constitute grounds for the revocation, suspension or refusal of renewal of the license or for the imposition of such penalty in lieu thereof as the Commissioner deems appropriate.

16. The records of the licensee relating to its business as a premium service company shall be kept entirely separate and distinct from records of any other business conducted by the licensee, and all items of accounts, whether real or nominal, control or subsidiary, in connection with its premium service company business shall be maintained separately and distinctly from accounts reflecting other business conducted by the licensee. Records and accounts with respect to premium service company business done in this State need not be maintained separately and distinctly from records of such business done in other states. Upon violation of this provision, the Commissioner may suspend the license of the licensee until such time as he has become satisfied, as a result of examination at the expense of the licensee, that proper separation and distinction of accounts has been made and will be maintained.

17. To comply with § 38-39-50(b), every licensee shall maintain on file each premium service agreement, or a duplicate original or photocopy thereof, and every original document relating thereto, all of which must bear an identifying account number.

Every such licensee shall maintain records which will readily disclose, as to each premium service agreement:

(a) Date of contract or acquisition.

(b) Name of the insured.

(c) Account number.

(d) Name of agent or producer of record.

(e) Principal balance at inception.

(f) Amount of service charge.

(g) Time balance.

(h) Initial charge.

(i) Number, interval and amount of payments.

(j) Exact disbursement of proceeds including the date, amount and purpose of all payments and names of all persons to whom any part of proceeds was paid, credited or allocated.

(k) Date of notice to insured that cancellation would be requested.

(*l*) Date of request for cancellation to insurer and requested cancellation date.

(m) Amount of return premium and its disposition.

18. The service charge in connection with a premium service agreement shall be applied only to the difference between the down payment and the total premium and shall not apply as to the initial charge which may be added only after computation of the service charge.

19. No notice of intent to request cancellation shall be given in advance of an actual default on the premium service agreement. Upon the occurrence of such default, the licensee may notify the insured by mail of its intention to request cancellation of the policies which are the subject of the agreement not less than 10 days after the date of mailing unless all payments then in default are received before the end of such 10 day period.

20. Not less than 5 days after the expiration of such period, if the default has not been cured, the licensee may mail a request for cancellation to the insurer, which request shall be accompanied by the proffer of the original or a photocopy of its authorization if such original or photocopy was not earlier furnished to the insurer, in which event reference may be made thereto.

The licensee shall mail a copy of the request for cancellation to the insured, and with respect to a policy of automobile liability insurance, such copy shall expressly and prominently inform the insured of his statutory duty to replace such insurance on or before the date of cancellation.

21. Every insurer, upon receipt of such request for cancellation, shall, subject to Section 22 hereof, cancel such contract as of the date requested and shall within a reasonable time, not more than 30 days, cause the gross return premium, if any, to be computed and paid or credited to, or for, the

account of the licensee. A copy of the statement relating to such return premiums shall be furnished by the insurer to the insured.

22. Where a valid statutory, regulatory or contractual provision requires that notice be given a particular period of time before cancellation shall become effective, the insurer shall not be required to effect cancellation prior to the elapse of the period of time prescribed by such statute, regulation or contract; the running of such time shall commence the second business day following receipt by the insurer of the request for cancellation.

23. Any excess of return premium over the amount to which the licensee is properly entitled under the premium service agreement shall be held and accounted for by the licensee in its fiduciary capacity and shall be promptly paid, and in no event more than 30 days after its receipt, to the insured.

Failure so to pay such funds to insureds or the commingling of such fiduciary funds with other funds of the licensee for longer than 30 days shall constitute sufficient grounds for the revocation, suspension or refusal of renewal of the license or the imposition of such lesser penalty as the Commissioner may deem appropriate.

24. This Regulation applies to a life insurance contract assigned to a licensee in connection with a premium service agreement and surrendered by such licensee for return by the insurer of any cash surrender value to the licensee; provided, however, that with respect to a life insurance contract, the licensee may retain, and the insurer may require surrender of, the original insurance contract.

25. In the event of cancellation of a premium service agreement by the insured, refund of the unearned service charge shall be in accordance with the customary short rate tables as used by insurers, copies of which are attached to and form a part of this Regulation.

26. No licensee shall sell or offer for sale, in connection with a premium service agreement or an application or request for such agreement, any insurance, commodity, or service of whatsoever nature as an inducement, condition, or consideration for entering into any such agreement.

The violation of this section shall constitute sufficient grounds for the revocation, suspension or refusal to renew the license.

27. No premium service agreement shall include, nor relate to, any subject other than the financing of premium with respect to the specific insurance policy or policies identified therein; and every agreement, undertaking or understanding relating to, affecting, or touching upon such premium service agreement shall be expressly incorporated therein so as to become a part thereof.

28. Each licensee shall furnish to the Commissioner, not later than March 1 of each year, on forms prescribed by him, an Annual Report on all business conducted under the license.

A special report shall be filed with the Commissioner each 6 months setting forth for each month of that period the following with totals:

(a) Number of premium service agreements written.

(b) Total premiums thereunder.

(c) Principal balances thereunder.

(d) Total service and initial charges.

(e) Number of policies cancelled pursuant to request.

29. No licensee shall accept or act pursuant to a premium service agreement which is not complete, nor shall any licensee or other person acting in its behalf complete, alter, vary or sign any such agreement except pursuant to the express, written instructions of the insured, a copy of which shall be retained and kept on file.

30. No premium service company, nor any employee, agent, or other person, acting in its behalf, shall give or offer to give any monies, supplies or services of whatsoever nature to any agent, producer of record or any other person as an inducement to such agent, producer or person to place premium service agreements with such premium service company; nor shall any such premium service company make or offer any rebate or other advantage or benefit to any borrower as an inducement to the effecting of a premium service agreement. Nothing herein shall preclude a premium service company from distributing advertising pieces or gifts containing the name and address of such premium service company and costing not more than one dollar.

31. Manifestly, in enacting the Premium Service Company Act of 1967, the General Assembly was responding to a vital public need, particularly with respect to the financing of premiums referable to automobile insurance, generally, and assigned risks, in particular. The legislation discloses a clear legislative design to erect safeguards around the financing of premiums for the protection not only of the insuring public but of the insurers themselves. In view of the General Assembly's obvious recognition of the public interest in connection with the subject of the financing of premiums, serious questions must arise as to whether any insurer which refuses recognition to premium service arrangements complying with the Act is serving the public trust implicit in its being licensed by South Carolina.

One Month Short Rate Table

Days Policy in Force	Percent of One Month Premium	Days Policy in Force	Percent of One Month Premium
1	11%	14	57
2	17	15	60
3	20	16	63
4	24	17	65
5	27	18	68
6	30	19	70
7	34	20	73
8	37	21	76
9	40	22	78
10	43	23	81
11	47	24	84
12	50	25	86
13	53	26	89
		27	92
		28	94
		29	97
		30	100

Two Month Short Rate Table

Days Policy in Force	Percent of Two Month Premium	Days Policy in Force	Percent of Two Month Premium
1	8%	19	42
2	11	20	43
3	14	21	45
4	17	22	47
5	19	23	48
6	20	24	50
7	22	25	52
8	24	26	53
9	25	27	55
10	27	28	57
11	29	29	58
12	30	30	60
13	32	31	61
14	34	32	63
15	35	33	64
16	37	34	65
17	38	35	67
18	40	36	68

Days Policy in Force	Percent of Two Month Premium
37	69
38	71
39	72
40	73
41	75
42	76
43	77
44	79
45	80
46	81
47	83
48	84
49	85
50	87
51	88
52	89
53	91
54	92
55	93
56	95
57	96
58	97
59	99
60	100

Three Month Short Rate Table

Days Policy in Force	Percent of Three Month Premium
1	6%
2	7
3	9
4	12
5	16
6	17
7	18
8	19
9	20
10	21
11	22
12	23
13	24
14	26
15	27
16	28
17	29
18	30
19	31
20	32
21	33
22	34
23	36
24	37
25	38
26	39
27	40
28	41
29	42
30	43
31	44
32	46
33	47
34	48
35	49
36	50
37	51
38	52
39	53
40	54
41	56
42	57
43	58
44	59
45	60
46	61
47–48	62
49	63
50	65
51–52	66
53	67
54	68
55	69
56–57	70
58	71
59	73
60–61	74
62	75
63	76
64	77
65–66	78
67	79
68	81
69–70	82
71	83
72	84

Days Policy in Force	Percent of Three Month Premium
73	85
74–75	86
76	87
77	89
78–79	90
80	91
81	92
82	93
83–84	94
85	95
86	97
87–88	98
89	99
90–92	100

Four Month Short Rate Table

Days Policy in Force	Percent of Four Month Premium
1	7%
2	8
3	10
4	11
5	13
6	14
7	16
8	17
9	18
10	19
11–12	20
13	21
14	22
15	23
16–17	24
18	25
19	26
20	27
21	28
22–23	29
24	30
25	31
26	32
27	33
28–29	34
30	35
31	36
32	37
33–34	38
35	39
36	40
37	41
38	42
39–40	43
41	44
42	45
43	46
44–45	47
46	48
47	49
48	50
49	51
50–51	52
52	53
53	54
54	55
55	56
56–57	57
58	58
59	59
60	60
61–62	61
63	62
64–65	63
66	64
67–68	65
69	66
70–71	67
72	68
73–74	69
75–76	70
77	71
78–79	72
80	73
81–82	74
83	75
84–85	76
86	77
87–88	78
89	79
90–91	80
92	81
93–94	82
95	83
96–97	84

Days Policy in Force	Percent of Four Month Premium
98	85
99–100	86
101	87
102–103	88
104	89
105–106	90
107	91
108–109	92
110	93
111–112	94
113–114	95
115	96
116–117	97
118	98
119–120	99
121–122	100

Five Month Short Rate Table

Days Policy in Force	Percent of Five Month Premium
1	6%
2	8
3	9
4	10
5	11
6	12
7	14
8	15
9	16
10	17
11–12	18
13	19
14–15	20
16	21
17–18	22
19	23
20–21	24
22	25
23–24	26
25–26	27
27	28
28	29
29–30	30
31	31
32–33	32
34	33
35–36	34
37–38	35
39	36
40–41	37
42	38
43	39
44–45	40
46–47	41
48	42
49–50	43
51	44
52–53	45
54	46
55–56	47
57	48
58–59	49
60–61	50
62	51
63	52
64–65	53
66	54
67–68	55
69	56
70–71	57
72–73	58
74	59
75–76	60
77–78	61
79	62
80–81	63
82–83	64
84–85	65
86–87	66
88–89	67
90–91	68
92–93	69
94–95	70
96	71
97–98	72
99–100	73
101–102	74
103–104	75
105–106	76
107–108	77
109–110	78
111–112	79
113	80

Days Policy in Force	Percent of Five Month Premium
114–115–116	81
117	82
118–119	83
120–121	84
122–123	85
124–125	86
126–127	87
128–129	88
130–131	89
132–133	90
134	91
135–136	92
137–138	93
139–140	94
141–142	95
143–144	96
145–146	97
147–148	98
149–150	99
151–152	100

Six Month Short Rate Table

Days Policy in Force	Percent of Six Month Premium
1	6%
2	7
3	8
4	9
5	10
6	11
7	12
8	13
9	14
10	15
11	16
12	17
13–14	18
15–16	19
17–18	20
19–20	21
21	22
22–23	23
24–25	24
26–27	25
28–29	26
30–31	27
32	28
33–34	29
35–36	30
37–38	31
39–40	32
41	33
42–43	34
44–45	35
46–47	36
48–49	37
50–51	38
52	39
53–54	40
55–56	41
57–58	42
59–60	43
61–62	44
63	45
64–65	46
66–67	47
68–69	48
70–71	49
72–73	50
74	51
75–76	52
77–78	53
79–80	54
81–82	55
83	56
84–85	57
86–87	58
88–89	59
90–91	60
92–93	61
94–95	62
96–98	63
99–100	64
101–102	65
103–104	66
105–107	67
108–109	68
110–111	69
112–114	70
115–116	71
117–118	72
119–120	73

Days Policy in Force	Percent of Six Month Premium
121–123	74
124–125	75
126–127	76
128–130	77
131–132	78
133–134	79
135–136	80
137–139	81
140–141	82
142–143	83
144–145	84
146–148	85
149–150	86
151–152	87
153–155	88
156–157	89
158–159	90
160–161	91
162–164	92
165–166	93
167–168	94
169–171	95
172–173	96
174–175	97
176–177	98
178–180	99
181–184	100

Seven Month Short Rate Table

Days Policy in Force	Percent of Seven Month Premium
1	6%
2	7
3	8
4	9
5–6	10
7	11
8	12
9	13
10	14
11	15
12–13	16
14	17
15–16–17	18
18	19
19–20–21	20
22–23	21
24–25	22
26–27	23
28–29–30	24
31	25
32–33–34	26
35–36	27
37–38	28
39–40	29
41–42	30
43–44	31
45–46	32
47–48	33
49–50–51	34
52–53	35
54–55	36
56–57	37
58–59	38
60–61	39
62–63	40
64–65–66	41
67	42
68–69–70	43
71–72	44
73–74	45
75–76	46
77–78–79	47
80	48
81–82–83	49
84–85	50
86–87	51
88–89	52
90–91	53
92–93	54
94–95	55
96–97	56
98–99–100	57
101–102	58
103–104	59
105–106	60
107–108–109	61
110–111	62
112–113–114	63
115–116	64
117–118–119	65
120–121–122	66
123–124–125	67
126–127	68
128–129–130	69

Days Policy in Force	Percent of Seven Month Premium
131–132–133	70
134–135	71
136–137–138	72
139–140	73
141–142–143	74
144–145–146	75
147–148–149	76
150–151	77
152–153–154	78
155–156–157	79
158–159	80
160–161–162	81
163–164	82
165–166–167	83
168–169–170	84
171–172	85
173–174–175	86
176–177–178	87
179–180–181	88
182–183	89
184–185–186	90
187–188	91
189–190–191	92
192–193	93
194–195–196	94
197–198–199	95
200–201–202	96
203–204–205	97
206–207	98
208–209–210	99
211–212–213	100

Eight Month Short Rate Table

Days Policy in Force	Percent of Eight Month Premium
1	6%
2	7
3–4	8
5	9
6	10
7	11
8–9	12
10	13
11–12	14
13	15
14	16
15–16	17
17–18–19	18
20–21	19
22–23–24	20
25–26	21
27–28	22
29–30–31	23
32–33–34	24
35–36	25
37–38	26
39–40–41	27
42–43	28
44–45–46	29
47–48	30
49–50	31
51–52–53	32
54–55	33
56–57–58	34
59–60	35
61–62	36
63–64–65	37
66–67–68	38
69–70	39
71–72	40
73–74–75	41
76–77	42
78–79–80	43
81–82	44
83–84	45
85–86–87	46
88–89–90	47
91–92	48
93–94	49
95–96–97	50
98–99	51
100–101–102	52
103–104	53
105–106	54
107–108–109	55
110–111	56
112–113–114	57
115–116	58
117–118	59
119–120–121	60
122–123–124	61
125–126–127	62
128–129–130	63
131–132–133	64
134–135–136	65

Days Policy in Force	Percent of Eight Month Premium
137–138–139	66
140–141–142	67
143–144–145	68
146–147–148	69
149–150–151–152	70
153–154	71
155–156–157–158	72
159–160	73
161–162–163–164	74
165–166	75
167–168–169–170	76
171–172–173	77
174–175–176	78
177–178–179	79
180–181–182	80
183–184–185	81
186–187–188	82
189–190–191	83
192–193–194	84
195–196–197	85
198–199–200	86
201–202–203	87
204–205–206	88
207–208–209	89
210–211–212	90
213–214–215	91
216–217–218	92
219–220–221	93
222–223–224	94
225–226–227–228	95
229–230	96
231–232–233–234	97
235–236	98
237–238–239–240	99
241–242–243	100

Nine Month Short Rate Table

Days Policy in Force	Percent of Nine Month Premium
1	5%
2–3	7
4	8
5–6	9
7	10
8–9	11
10	12
11–12	13
13	14
14–15	15
16	16
17–18–19	17
20–21–22	18
23–24	19
25–26–27	20
28–29–30	21
31–32	22
33–34–35	23
36–37–38	24
39–40	25
41–42–43	26
44–45–46	27
47–48–49	28
50–51–52	29
53–54–55	30
56–57	31
58–59–60	32
61–62	33
63–64–65	34
66–67–68	35
69–70	36
71–72–73	37
74–75–76	38
77–78–79	39
80–81–82	40
83–84–85	41
86–87	42
88–89–90	43
91–92–93	44
94–95	45
96–97–98	46
99–100–101	47
102–103	48
104–105–106	49
107–108–109	50
110–111–112	51
113–114–115	52
116–117	53
118–119–120	54
121–122–123	55
124–125	56
126–127–128	57
129–130–131	58
132–133	59
134–135–136	60
137–138–139–140	61

Days Policy in Force	Percent of Nine Month Premium
141–142–143	62
144–145–146–147	63
148–149–150	64
151–152–153–154	65
155–156–157	66
158–159–160	67
161–162–163	68
164–165–166–167	69
168–169–170–171	70
172–173–174	71
175–176–177–178	72
179–180–181	73
182–183–184	74
185–186–187	75
188–189–190–191	76
192–193–194–195	77
196–197–198	78
199–200–201–202	79

Days Policy in Force	Percent of Nine Month Premium
203–204–205	80
206–207–208	81
209–210–211	82
212–213–214–215	83
216–217–218	84
219–220–221–222	85
223–224–225–226	86
227–228–229	87
230–231–232	88
233–234–235	89
236–237–238–239	90
240–241–242	91
243–244–245–246	92
247–248–249	93
250–251–252–253	94
254–255–256	95
257–258–259	96
260–261–262–263	97
264–265–266	98
267–268–269–270	99
271–272–273–274	100

Ten Month Short Rate Table

Days Policy in Force	Percent of Ten Month Premium
1	5%
2	6
3	7
4–5	8
6–7	9
8	10
9–10	11
11–12	12
13	13
14–15	14
16–17	15
18	16
19–20–21	17
22–23–24	18
25–26–27	19
28–29–30	20
31–32–33	21
34–35–36	22
37–38–39	23
40–41–42	24
43–44–45	25
46–47–48	26
49–50–51–52	27
53–54	28
55–56–57	29
58–59–60–61	30

Days Policy in Force	Percent of Ten Month Premium
62–63	31
64–65–66–67	32
68–69	33
70–71–72	34
73–74–75–76	35
77–78	36
79–80–81–82	37
83–84–85	38
86–87	39
88–89–90–91	40
92–93–94	41
95–96–97	42
98–99–100	43
101–102–103	44
104–105–106	45
107–108–109	46
110–111–112	47
113–114–115	48
116–117–118	49
119–120–121–122	50
123–124	51
125–126–127	52
128–129–130	53
131–132–133	54
134–135–136–137	55
138–139	56

Days Policy in Force	Percent of Ten Month Premium
140–141–142	57
143–144–145–146	58
147–148	59
149–150–151–152	60
153–154–155–156	61
157–158–159	62
160–161–162–163	63
164–165–166–167	64
168–169–170–171	65
172–173–174	66
175–176–177–178	67
179–180–181–182	68
183–184–185–186	69
187–188–189–190	70
191–192–193	71
194–195–196–197	72
198–199–200–201	73
202–203–204–205	74
206–207–208	75
209–210–211–212	76
213–214–215–216–217	77
218–219–220	78
221–222–223–224	79
225–226–227	80
228–229–230–231–232	81
233–234–235	82
236–237–238–239	83
240–241–242	84
243–244–245–246–247	85
248–249–250–251	86
252–253–254	87
255–256–257–258	88
259–260–261–262	89
263–264–265–266	90
267–268–269	91
270–271–272–273	92
274–275–276–277	93
278–279–280–281	94
282–283–284–285	95
286–287–288	96
289–290–291–292	97
293–294–295–296	98
297–298–299–300	99
301–302–303–304	100

Eleven Month Short Rate Table

Days Policy in Force	Percent of Eleven Month Premium
1	5%
2	6
3–4	7
5	8
6–7	9
8–9	10
10–11	11
12–13	12
14–15	13
16	14
17–18	15
19–20	16
21–22–23	17
24–25–26–27	18
28–29	19
30–31–32–33	20
34–35–36–37	21
38–39	22
40–41–42–43	23
44–45–46–47	24
48–49	25
50–51–52–53	26
54–55–56–57	27
58–59–60	28
61–62–63	29
64–65–66–67	30
68–69–70	31
71–72–73	32
74–75–76	33
77–78–79–80	34
81–82–83	35
84–85–86	36
87–88–89–90	37
91–92–93	38
94–95–96	39
97–98–99–100	40
101–102–103–104	41
105–106	42
107–108–109–110	43
111–112–113–114	44
115–116	45
117–118–119–120	46
121–122–123–124	47
125–126	48
127–128–129–130	49
131–132–133–134	50

Days Policy in Force	Percent of Eleven Month Premium
135–136–137	51
138–139–140	52
141–142–143	53
144–145–146–147	54
148–149–150	55
151–152–153	56
154–155–156–157	57
158–159–160	58
161–162–163	59
164–165–166–167	60
168–169–170–171	61
172–173–174–175	62
176–177–178–179–180	63
181–182–183	64
184–185–186–187–188	65
189–190–191–192	66
193–194–195–196	67
197–198–199–200	68
201–202–203–204	69
205–206–207–208–209	70
210–211–212–213	71
214–215–216–217	72
218–219–220–221	73
222–223–224–225	74
226–227–228–229	75
230–231–232–233–234	76
235–236–237–238	77
239–240–241–242	78
243–244–245–246–247	79
248–249–250	80
251–252–253–254–255	81
256–257–258	82
259–260–261–262–263	83
264–265–266–267	84
268–269–270–271	85
272–273–274–275–276	86
277–278–279–280	87
281–282–283–284	88
285–286–287–288	89
289–290–291–292	90
293–294–295–296	91
297–298–299–300–301	92
302–303–304	93
305–306–307–308–309	94
310–311–312–313	95
314–315–316–317	96
318–319–320–321–322	97
323–324–325	98
326–327–328–329–330	99
331–332–333–334–335	100

One Year Short Rate Table

Days Policy in Force	Percent of One Year Premium
1	5%
2	6
3–4	7
5–6	8
7–8	9
9–10	10
11–12	11
13–14	12
15–16	13
17–18	14
19–20	15
21–22	16
23–25	17
26–29	18
30–32	19
33–36	20
37–40	21
41–43	22
44–47	23
48–51	24
52–54	25
55–58	26
59–62	27
63–65	28
66–69	29
70–73	30
74–76	31
77–80	32
81–83	33
84–87	34
88–91	35
92–94	36
95–98	37
99–102	38
103–105	39
106–109	40
110–113	41
114–116	42
117–120	43
121–124	44

Days Policy in Force	Percent of One Year Premium	Days Policy in Force	Percent of One Year Premium
125–127	45	238–241	73
128–131	46	242–246	74
132–135	47	247–250	75
136–138	48	251–255	76
139–142	49	256–260	77
143–146	50	261–264	78
147–149	51	265–269	79
150–153	52	270–273	80
154–156	53	274–278	81
157–160	54	279–282	82
161–164	55	283–287	83
165–167	56	288–291	84
168–171	57	292–296	85
172–175	58	297–301	86
176–178	59	302–305	87
179–182	60	306–310	88
183–187	61	311–314	89
188–191	62	315–319	90
192–196	63	320–323	91
197–200	64	324–328	92
201–205	65	329–332	93
206–209	66	333–337	94
210–214	67	338–342	95
215–218	68	343–346	96
219–223	69	347–351	97
224–228	70	352–355	98
229–232	71	356–360	99
233–237	72	361–365	100

69–11.1. Regulation of Credit Insurance.

This regulation replaces Regulation 69-11 and provides one comprehensive regulation for all insurance sold in connection with the Consumer Finance Act or the Consumer Protection Code, as amended.

A. Background and Purpose. 1976 Code §§ 34-29-10 et seq. is known as the Consumer Finance Act and provides that accident and health or property insurance sold in conjunction with consumer loans, as defined in Act 988, shall be subject to rules and regulations adopted by the South Carolina Insurance Commission. Such rules and regulations are contained in Regulation 69-11 issued October 13, 1967. 1976 Code Title 37 is known as the South Carolina Consumer Protection Code. Act 686 of 1976 amended Act 1241 in many particulars, but neither Act 1241 nor Act 686 amended any of the insurance or provisions of 1976 Code §§ 34-29-10 et seq., except to provide that such sections shall apply only to restricted loans and restricted lenders, as defined in Act 686. It is the purpose of this Regulation to replace Regulation 69-11 and provide one comprehensive regulation for all insurance sold in connection with the Consumer Finance Act (1976 Code §§ 34-29-10 et seq) or the Consumer Protection Code (1976 Code Title 37 as amended by Act 686 of 1976).

B. Definitions. For the purpose of this Regulation definitions of words or phrases herein relating to types of loans and other financial transactions on which insurance is permitted and relating to all types of lenders and financial organizations that are subject to the types of supervision or regulation as defined in the Consumer Finance Act or the Consumer Protection Code, shall be those definitions set forth in said Act and said Code, respectively.

C. Provisions Applicable to Restricted Loans and Restricted Lenders.

(1) Forms.

(a) General: All forms of policies, certificates, or other evidence of insurance used in South Carolina or covering South Carolina lives, property or interests must be filed with and approved by the Chief Insurance Commissioner before use in this State. Forms offered for filing and approval must be submitted in duplicate and, if approved for use in the State, one counterpart of each form will be marked as approved and returned to the insurer affected to serve as evidence of compliance with the Act and § 38-61-20 of the 1976 Code. Filing and approval of forms as required hereunder shall be deemed prima facie evidence of compliance with the provisions of the South Carolina Consumer Finance Act by the insurer and the agent.

The Chief Insurance Commissioner shall disapprove any form if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or which encourages misrepresentation of coverage or is contrary to any provision of the South Carolina Code of Laws or any rule or regulation issued thereunder.

(b) Life Insurance: Where the borrower pays for the cost of credit life insurance written individually or under a group contract, no form will be approved unless the insurer can demonstrate that the coverage provided in such form bears a reasonable and bona fide relation to the hazard or risk of loss to be assumed by the insurer proposing to issue such form of contract.

No form providing level term life insurance will be approved unless the insurer offering such form can demonstrate to the satisfaction of the Commission that the coverage provided thereunder is a lawful requirement of the Act.

If individual life insurance policies do not state the reserve method used by the insurer, the insurer must notify the Insurance Department of its reserve method pursuant to §§ 38-5-60, 38-9-170, and 38-9-180 of the 1976 Code.

(c) Accident and Health Insurance: All coverages must be written on forms providing for a maximum three (3) day waiting period for a covered disability with benefits to be retroactive to the first day of disability.

(d) Property Insurance: Property insurance must cover the property of a borrower used to secure a loan, and the amount of insurance must not exceed the reasonable value of the property insured.

Single interest coverage and dual interest coverage may be offered pursuant to the Act, but the borrower must have the option to purchase either single interest or dual interest. If the lender does not represent an insurer writing dual interest property insurance, a reasonable effort must be made by the lender to obtain dual interest property insurance for the account of the borrower if he requests such coverage. When a borrower specifically requests dual interest coverage, he may also request a term of coverage to exceed the term of the secured loan.

No insurer or agent may lawfully issue a policy or charge an insurance premium to cover property securing a loan if such a property is not eligible for coverage under the forms approved for use by such insurer in this State.

(e) Non-Filing Insurance: Non-filing insurance is authorized under the provisions of the South Carolina Consumer Protection Code, and such coverage may be written on forms and rates as approved by the Chief Insurance Commissioner, provided that the premiums payable for such insurance in lieu of perfecting a security interest do not exceed the fees and charges authorized by law.

(2) Basic Statistical Plan. To comply with 1976 Code § 34-29-160, which specifies that credit accident and health and credit property insurance rates shall be deemed excessive if the loss ratio resulting from their use may reasonably be expected to be less than fifty percent, the Commission has adopted a Basic Statistical Plan to be used by all insurers writing insurance pursuant to the Act. The data specified in the Basic Statistical Plan shall be filed under oath by March 1 of each year for the business of the preceding calendar year, and shall be submitted both as part of the Annual Statement, on forms prescribed by the Chief Insurance Commissioner, and as a separate document, sworn to by an officer of the company. The data required are:

Line of Insurance	Direct Premiums Written	Direct Premiums Earned	Direct Losses Paid (Deducting Salvage)	Direct Losses Incurred
Accident & Health	(1)	(2)	(3)	(4)
(1) Group and Individual Accident and Health				
Property				
(1) Automobile Fire and Theft Single Interest				
(2) Automobile Collision Single Interest				
(3) Household Goods Single Interest				
(4) Household Goods Dual Interest				

The definitions of Direct Premiums Written, Direct Premiums Earned, Direct Losses Paid (Deducting Salvage) and Direct Losses Incurred shall be the definitions applicable to the Annual Statement.

The Commission may take all reasonable steps to insure the accuracy of the data submitted. Failure of the entries submitted as part of the Annual Statement to agree with the corresponding entries submitted as a separate document will be prima facie evidence of inaccuracy. Other indications of possible inaccuracy may be investigated.

(3) Compilation of Statistics by Commission—Determination of Rates. As soon as practicable after March 1 of each year, after satisfying itself of the accuracy of the data submitted under the Basic Statistical Plan, the Commission will compile the total earned premiums and incurred losses for all insurers submitting data, for each line of insurance, for the preceding calendar year. These totals, together with such corresponding totals for previous calendar years as are available, will be adjusted to a common rate base, to determine the rate for each line of insurance which may reasonably be expected to produce a loss ratio of not less than fifty percent for the following calendar year. In making this determination the Commission shall give due consideration to past and prospective loss experience and to all other relevant factors within and outside of this State.

(4) Promulgation of Tentative Rates by Commission. On or before August 1 of each year, the Commission shall notify all insurers writing credit insurance under 1976 Code §§ 34-29-10 et seq, of the rates which it believes may reasonably be expected to produce a loss ratio of not less than fifty percent in the following calendar year. Every insurer which feels aggrieved by any of the rates so promulgated shall have fifteen days to request a public hearing with respect to such rate or rates. Following such hearing or hearings, the Commission shall either modify its previous determination or reaffirm it. Such modification or reaffirmation shall be made before October 1.

(5) Promulgation of Final Rates by Commission. On or before October 1 of each year, the Commission shall notify all insurers of the rates which shall become effective on new policies issued on or after January 1 of the following year.

(6) Filing of Rates by Insurers. On or before December 1 of each year, each insurer shall notify the Commission of its intention to use rates no higher than the final rates promulgated by the Commission for the lines of insurance which it writes.

D. Provisions Applicable to Lenders and Financial Organizations and to Loans and Other Financial Transactions Subject to Article 4 of the Consumer Protection Code [1976 Code Title 37, Chapter 4].

(1) Application. These provisions are applicable to insurance provided or to be provided in relation to a consumer credit sale, a consumer credit lease, or a consumer loan, other than as excepted in 1976 Code § 37-4-102, Subsection (2) of the Consumer Protection Code.

(2) Forms.

(a) General: All forms of policies, certificates or other evidence of insurance used in South Carolina or covering South Carolina lives, property or interests must be filed with and approved

by the Chief Insurance Commissioner before use in this State. Forms offered for filing and approval must be submitted in duplicate, and if approved for use in the State, one counterpart of each form will be marked as approved and returned to the insurer affected to serve as evidence of compliance with the South Carolina Consumer Protection Code and § 38-61-20 of the 1976 Code. Filing and approval of forms as required hereunder shall be deemed prima facie evidence of compliance with the provisions of the South Carolina Consumer Protection Code by the insurer and the agent.

The Chief Insurance Commissioner shall disapprove any form if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation of coverage, or is contrary to any provision of the South Carolina Code of Laws or any rule or regulation issued thereunder.

(b) Life Insurance: Where the borrower pays for the cost of credit life insurance written individually or under a group contract, no form will be approved unless the insurer can demonstrate that the coverage provided in such form bears a reasonable and bona fide relation to the hazard or risk of loss to be assumed by the insurer proposing to issue such form of contract.

If individual life insurance policies do not state the reserve method used by the insurer, the insurer must notify the Insurance Department of its reserve method pursuant to §§ 38-5-60, 38-9-170 and 38-9-180 of the 1976 Code.

(c) Accident and Health Insurance: All coverages of credit accident and health insurance written hereunder must be written on forms providing for either a fourteen (14) or thirty (30) day retroactive coverage.

(d) Property Insurance: Property insurance must cover the property of a borrower used to secure a loan, and the amount of insurance must not exceed the reasonable value of the property insured.

No insurer or agent may lawfully issue a policy or charge an insurance premium to cover property securing a loan if such property is not eligible for coverage under the forms approved for use by such insurer in this State.

(e) Non-Filing Insurance. Non-filing insurance is authorized under the provisions of the South Carolina Consumer Protection Code, and such coverage may be written on forms and rates as approved by the Chief Insurance Commissioner, provided that the premiums payable for such insurance in lieu of perfecting a security interest do not exceed the fees and charges authorized by law.

(3) Basic Statistical Plan. To comply with 1976 Code § 37-4-203(4) of the South Carolina Consumer Protection Code, which provides that premium rates and premium rate levels for credit accident and health insurance shall be calculated to produce and maintain a ratio of losses incurred to premiums earned, or reasonably expected to be earned, of approximately fifty percent, the Commission has adopted a Basic Statistical Plan to be used by all insurers writing such insurance under the Code. The data specified in the Basic Statistical Plan shall be filed under oath by March 1 of each year for the business of the preceding calendar year, and shall be submitted both as a part of the Annual Statement, and on separate forms prescribed by the Chief Insurance Commissioner, sworn to by an officer of the company.

The Commission may take all reasonable steps to insure the accuracy of the data submitted. Failure of the entries submitted as a part of the Annual Statement to agree with the corresponding entries submitted on the separate forms prescribed by the Chief Insurance Commissioner will be deemed prima facie evidence of inaccuracy. Other indications of possible inaccuracy may be investigated.

(4) Compilation of Statistics by Commission—Determination of Rates. As soon as practicable after March 1 of each year, after satisfying itself of the accuracy of the data submitted under the Basic Statistical Plan, the Commission will compile the total earned premiums and incurred losses for all insurers submitting data, for such credit accident and health insurance, for the preceding calendar year. These totals, together with such corresponding totals for previous calendar years as are available, will be adjusted to a common rate base, to determine the rate for each plan of benefits and class of business for credit accident and health insurance which may be calculated to produce and maintain a ratio of losses incurred, or reasonably expected to be incurred, to premiums earned, or

reasonably expected to be earned, of approximately fifty percent. In making this determination, the Commission shall give due consideration to past and prospective loss experience and to all other relevant factors within and outside of this State.

(5) Promulgation of Tentative Rates by Commission. On or before August 1 of each year, the Commission shall notify all insurers writing credit accident and health insurance through Supervised Lenders under the South Carolina Consumer Protection Code, of the rates which it believes may reasonably be expected to produce and maintain a ratio of losses incurred, or reasonably expected to be incurred, to premiums earned, or reasonably expected to be earned, of approximately fifty percent in the following calendar year. Every insurer which feels aggrieved by any of the rates so promulgated shall have fifteen days to request a public hearing with respect to such rate or rates. Following such hearing, or hearings if more than one, the Commission shall either modify its previous determination or reaffirm it. Such modification or reaffirmation shall be made before October 1.

(6) Promulgation of Final Rates by Commission. On or before October 1 of each year, the Commission shall notify all insurers of the rates which shall become effective on new policies of credit accident and health insurance issued hereunder on or after January 1 of the following year.

(7) Filing of Rates by Insurers. On or before December 1 of each year, each insurer shall notify the Commission of its intention to use rates no higher than the final rates of credit accident and health insurance promulgated by the Commission for the plan of benefits of such insurance which it writes.

(8) Implementation of this Regulation. The Basic Statistical Plan applicable to all credit insurance sold in conjunction with Restricted loans, as defined in B., shall be the Basic Statistical Plan prescribed by C.(2). This Plan shall be used for the recording of statistics by insurers for calendar year 1977, to be reported by March 1, 1978.

The Basic Statistical Plan applicable to all credit insurance sold in conjunction with Supervised Loans, as defined in B., shall be in conformance with D.(3), and as promulgated by Order 01-77.

The South Carolina Insurance Commission will notify all interested insurers by Order of any change in either Basic Statistical Plan applicable to the business of a calendar year by July 1 of the preceding calendar year.

69–12. Variable Contracts.

PART A—VARIABLE ANNUITIES

Article I: Authority.

Part A of this Regulation, applicable to variable annuities, is promulgated under the authority of *S. C. Code* § 38-67-40 (1976).

Article II: Definitions.

As used in Part A of this Regulation:

(1) The term "variable annuity" shall mean any policy or contract which provides for annuity benefits which vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in *S. C. Code* § 38-67-10 (1976) or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(2) "Agent" shall mean any individual licensed by the Commissioner as a life insurance agent.

(3) "Commissioner" shall mean the Chief Insurance Commissioner of South Carolina.

Article III: Qualification of Insurance Companies to Issue Variable Annuities.

(1) No insurance company shall deliver or issue for delivery variable annuities within this State unless (a) it is licensed or organized to do a life insurance or annuity business in this State, and (b) the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this State. In this connection, the Commissioner shall consider among other things:

(i) The history and financial condition of the company;

(ii) The character, responsibility and fitness of the officers and directors of the company;

(iii) The law and regulation under which the company is authorized in its state of domicile to issue variable annuities.

(2) If the company is a subsidiary of an admitted life insurance company, or affiliated with such company by common management or ownership, it may be deemed by the Commissioner to have satisfied the provisions of clause (b) of Paragraph (1) hereof if either it or such admitted life company satisfies the aforementioned provisions; provided, further, that companies licensed and having a satisfactory record of doing business in this State for a period of at least three years may be deemed to have satisfied the Commissioner with respect to clause (b) of Paragraph (1) above.

(3) Before any company shall deliver or issue for delivery variable annuities within this State it shall submit to the Commissioner (a) a general description of the kinds of variable annuities it intends to issue, (b) if requested by the Commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable annuities, and (c) if requested by the Commissioner, biographical data with respect to officers and directors of the company on such forms as the Commissioner may approve.

Article IV: Separate Account.

A domestic company issuing variable annuities shall establish one or more separate accounts pursuant to *S. C. Code* § 38-67-10 (1976), subject to the following provisions of this Article:

(1)(a) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Paragraph (1)(b), (i) amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this State governing the investments of life insurance companies, and (ii) the investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(b) Reserves for (i) benefits guaranteed as to dollar amount and duration, and (ii) funds guaranteed as to principal amount or stated rate of interest may be maintained in a separate account, if a portion of the assets of such separate account at least equal to such reserve liability is invested in accordance with the laws and regulations of this State governing the investments of life insurance companies. Such portion of the assets also shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(c) With respect to 75% of the market value of the total assets in a separate account, no company shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market, would exceed 10% of the market value of the assets of said separate account; provided, however, that the Commissioner may waive such limitation if, in his opinion, such waiver will not render the operation of such separate account hazardous to the public or policyholders in this State.

(d) Unless otherwise permitted by law or approved by the Commissioner, no company shall purchase or otherwise acquire for its separate accounts the voting securities of any issuer if as a result of such acquisition the insurance company and its separate accounts, in the aggregate, will own more than 10% of the total issued and outstanding voting securities of such issuer; provided, that the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interest in such accounts.

(e) The limitations provided in Paragraphs (1)(c) and (1)(d) above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, provided that the investments of such investment company comply in substance with Paragraphs (1)(c) and (1)(d) hereof.

(2) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; provided, that unless otherwise approved by the Commissioner, the portion, if any, of the assets of such separate account equal to the company's reserve liability with regard to the

benefits and funds referred to in clauses (i) and (ii) of Paragraph (1)(b) shall be valued in accordance with the rules otherwise applicable to the company's assets.

(3) If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(4) Notwithstanding any other provisions of law, a company may

(a) with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust, exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the company, or

(b) with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the company. Such committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets.

A company, committee, board or other body may make such other provisions in respect to any such separate account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect; provided that the Commissioner approves such provisions as not hazardous to the public or the company's policyholders in this State.

(5) No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in the case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (a) by a transfer of cash, or (b) by a transfer of securities having a valuation which could be readily determined in the marketplace, provided that such transfer of securities is approved by the Commissioner. The Commissioner may authorize other transfers among such accounts, if, in his opinion, such transfers would not be inequitable.

(6) The company shall maintain in each separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the Commissioner.

(7) Rules under any provision of the insurance laws of this State or any regulation applicable to the officers and directors of insurance companies with respect to conflict of interest shall also apply to members of any separate accounts committee, board or other similar body. No officer or director of such company nor any member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

Article V: Filing of Contracts.

The filing requirements applicable to variable annuities shall be those filing requirements otherwise applicable under existing statutes and regulations of this State with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate.

Article VI: Variable Annuity Contracts.

(1) Any variable annuity providing benefits payable in variable amounts delivered or issued for delivery in this State shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a clear and prominent statement to the effect that the benefits thereunder are on a variable basis.

(2) Illustrations of benefits payable under any variable annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience;

provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits.

(3) No individual variable annuity contract calling for the payment of periodic stipulated payments to the insurer shall be delivered or issued for delivery in this State unless it contains in substance the following provision or provisions which in the opinion of the Commissioner are more favorable to the holders of such contracts:

(a) A provision that there shall be a period of grace of 30 days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom;

(b) A provision that, at any time within one year from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom;

(4) Any variable annuity contract delivered or issued for delivery in this State shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder, and may guarantee that expense and/or mortality results shall not adversely affect such dollar amounts. In the case of an individual variable annuity contract under which the expense and mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be stipulated in the contract.

In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(a) The annual net investment increment assumption shall not exceed 5% except with the approval of the Commissioner.

(b) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, ultimate, or any modification of that table not having a lower life expectancy at any age, or, if approved by the Commissioner, from another table.

"Expense" as used in this Paragraph, may exclude some or all taxes, as stipulated in the contract.

(5) The reserve liability for variable annuities shall be established pursuant to the requirements of *S. C. Code* § 38-9-180 (1976) (the Standard Valuation Law) in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Article VII: Nonforfeiture Benefits.

(1) This Article shall not apply to any (i) reinsurance, (ii) group annuity contract purchased in connection with one or more retirement plans or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, or other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, (iii) premium deposit fund, (iv) investment annuity, (v) immediate annuity, (vi) deferred annuity contract after annuity payments have commenced, (vii) reversionary annuity, or to any (viii) contract which is to be delivered outside this state through an agent or other representative of the company issuing the contract.

(2) To the extent that any variable annuity contract provides benefits which do not vary in accordance with the investment performance of a separate account before the annuity commencement date, such contract shall contain provisions which satisfy the requirements of Chapter 69 of Title 38 of 1976 Code, (the Standard Nonforfeiture Law for Deferred Annuities) and shall not otherwise be subject to this Article.

(3) In the case of a contract issued one hundred eighty (180) days after the effective date of this regulation, no variable annuity contract, except as stated in Paragraphs (1) and (2), shall be delivered

or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(a) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan described in the contract that complies with Paragraph (7). Such description will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(b) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit as described in the contract that complies with Paragraph (8). The contract may provide that the company reserves the right, at its option, to defer the determination and payment of any cash surrender benefit for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

(c) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(4) The minimum values as specified in this Article of any paid-up annuity, cash surrender or death benefits available under a variable annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this paragraph.

The minimum nonforfeiture amount on any date prior to the annuity commencement date shall be an amount equal to the percentages of net considerations (as specified in Paragraph 5) increased (or decreased) by the net investment return allocated to the percentages of net considerations, which amount shall be reduced to reflect the effect of:

(i) any partial withdrawals from or partial surrenders of the contract;

(ii) the amount of any indebtedness on the contract, including interest due and accrued;

(iii) an annual contract charge not less than zero and equal to (a) the lesser of thirty dollars ($30.00) and 2% of the end of year contract value less (b) the amount of any annual contract charge deducted from any gross considerations credited to the contract during such contract year; and

(iv) a transaction charge of ten dollars ($10.00) for each transfer to another separate account or to another investment division within the same separate account.

"Net investment return" means the rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in the contract, or in the case of a contract issued by a non-profit corporation under which the contractholder participates fully in the investment, mortality and expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract shall be determined at least monthly.

The annual contract charge of thirty dollars ($30.00) and the transaction charge of ten dollars ($10.00) referred to above will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph (6).

(5) The percentages of net considerations used to define the minimum nonforfeiture amount in Paragraph (4) shall meet the requirements of this paragraph.

(a) With respect to contracts providing for periodic considerations, the net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars ($30.00) and less a collection charge of one dollar and twenty-five cents ($1.25) per consideration credited to the contract during that contract year less any charges for premium taxes. The percentages of net

considerations shall be sixty-five percent (65%) for the first contract year and eighty-seven and one-half percent (87 ½%) for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(b) With respect to contracts providing for a single consideration, the net consideration used to define the minimum nonforfeiture amount shall be the gross consideration less a contract charge of seventy-five dollars ($75.00) and less any charge for premium taxes. The percentage of the net consideration shall be ninety percent (90%).

The annual contract charge of thirty dollars ($30.00), the collection charge of one dollar and twenty-five cents ($1.25) per collection, and the single consideration contract charge of seventy-five dollars ($75.00) referred to above, will be adjusted to reflect changes in the Consumer Price Index in accordance with Paragraph (6).

(6) Demonstration that a contract's nonforfeiture amounts comply with this Article shall be based on the following assumptions:

(a) Values should be tested at the ends of each of the first twenty (20) contract years;

(b) A net investment return of 7% per year should be used;

(c) If the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

(d) In determining the state premium tax, if any, applicable to the contract, the state of residence should be assumed to equal the state of delivery;

(e) With respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

(f) With respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

(g) The following contract charges should be used:

(1) For contracts filed in 1980 or earlier, the annual contract charge of thirty dollars ($30.00) referred to in Paragraphs (4) and (5), the charge of ten dollars ($10.00) per transfer referred to in Paragraph (4), the collection charge of one dollar and twenty-five cents ($1.25) per consideration referred to in Paragraph (5), and the contract charge of seventy-five dollars ($75.00) referred to in Paragraph (5)(b).

(2) For contracts filed in 1981 or later, the above contract charges multiplied by the ratio of (i) the Consumer Price Index for June of the calendar year preceding the date of filing, to (ii) the Consumer Price Index for June, 1979.

(h) If the contract provides for allocation of considerations to both fixed and variable accounts, 100% of the considerations should be assumed to be allocated to the variable account.

As used herein, the Consumer Price Index means such Index for all urban consumers for all items as published by the Bureau of Labor Statistics of the United States Department of Labor or its successor.

If publication of the Consumer Price Index ceases, or if such Index otherwise becomes unavailable or is altered in such a way as to be unusable, the Commissioner will substitute an index he deems to be suitable.

(7) Any paid-up annuity benefit available under a variable annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on the date. Such present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(8) For variable annuity contracts which provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount next computed after the request for surrender is received by the company. The death benefit under such contracts shall be at least equal to the cash surrender benefits.

(9) Any variable annuity contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the annuity commencement date shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Notwithstanding the requirements of this Article, a variable annuity contract may provide under the situations specified in (a) or (b) below that the company, at its option, may cancel the annuity and pay the contractholder its accumulated value and by such payment be released of any further obligation under such contract:

(a) if at the time the annuity becomes payable the accumulated value is less than $2,000, or would provide an income the initial amount of which is less than $20 per month; or

(b) if prior to the time the annuity becomes payable under a periodic payment variable annuity contract no considerations have been received under the contract for a period of two (2) full years and both (i) the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract and (ii) the accumulated value, amount to less than $2,000.

(11) For any variable annuity contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Paragraph (4), additional benefits payable (a) in the event of total and permanent disability, (b) as reversionary annuity or deferred reversionary annuity benefits, or (c) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Article. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Article VIII: Required Reports.

(1) Any company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his last address known to the company, a statement or statements reporting the investments held in the separate account. The company shall submit annually to the Commissioner a statement of business of its separate account or accounts in such form as may be approved by the Commissioner.

(2) Any company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his last address known to the company a statement reporting as of a date not more than four months previous to the date of mailing. In the case of an annuity contract under which payments have not yet commenced, the report shall contain (a) the number of accumulation units credited to such contract and the dollar value of a unit, or (b) the value of the contractholder's account.

Article IX: Foreign Companies.

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to policyholders and the public which is substantially equal to that provided by these regulations, the Commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

Article X: Qualifications of Agents for the Sale of Variable Annuities.

(1)(a) No person may sell or offer for sale in this state any variable annuity contract unless such person is an agent and has filed with the Commissioner, in a form satisfactory to the Commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable annuity contracts by any federal or state securities law.

(b) Any examination required by the Commissioner for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and sale of variable annuity contracts as the Commissioner deems appropriate.

(2) Any person qualified in this state under this Article to sell or offer to sell variable annuity contracts shall immediately report to the Commissioner:

(a) Any suspension or revocation of his agents license in any other state or territory of the United States;

(b) The imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable annuity contracts;

(c) Any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(3) The Commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualification under this Article to sell or offer to sell variable annuity contracts or impose monetary penalties upon any ground that would warrant similar disciplinary action arising out of the agent's sale of other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable annuity contracts.

PART B—VARIABLE LIFE INSURANCE

Article I: Authority.

Section 1. Authority.

Part B of this Regulation, applicable to variable life insurance, is promulgated under the authority of **S. C. Code** § 38-67-40 (1976).

Article II: Definitions.

As used in Part B of this Regulation:

Section 1. Affiliate.

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

Section 2. Agent.

"Agent" means any individual licensed by the Commissioner as a life insurance agent.

Section 3. Assumed Investment Rate.

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

Section 4. Benefit Base.

"Benefit base" means the amount to which the net investment return is applied.

Section 5. Commissioner.

"Commissioner" means the Chief Insurance Commissioner of South Carolina.

Section 6. Control.

"Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or

holds proxies representing more than ten (10) percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the Commissioner that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Section 7. Flexible Premium Policy.

"Flexible premium policy" means any variable life insurance policy other than a scheduled premium policy as defined in this Article.

Section 8. General Account.

"General account" means all assets of the insurer other than assets in separate accounts established pursuant to *S. C. Code* § 38-67-10 (1976) or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

Section 9. Incidental Insurance Benefit.

"Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

Section 10. May.

"May" is permissive.

Section 11. Minimum Death Benefit.

"Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

Section 12. Net Investment Return.

"Net Investment Return" means the rate of investment return in a separate account to be applied to the benefit base.

Section 13. Person.

"Person" means an individual, corporation, partnership, association, trust, or fund.

Section 14. Policy Processing Day.

"Policy processing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

Section 15. Scheduled Premium Policy.

"Scheduled premium policy" means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

Section 16. Separate Account.

"Separate account" means a separate account established pursuant to *S. C. Code* § 38-67-10 (1976), or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Section 17. Shall.

"Shall" is mandatory.

Section 18. Variable Death Benefit.

"Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

Section 19. Variable Life Insurance Policy.

"Variable life insurance policy" means any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to *S. C. Code* § 38-67-10

(1976), or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Article III: Qualification of Insurer to Issue Variable Life Insurance.

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

SECTION 1. Licensing and Approval to do Business in this State.

An insurer shall not deliver or issue for delivery in this state any variable life insurance policies unless:

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

(b) the insurer has obtained the written approval of the Commissioner for the issuance of variable life insurance policies in this state. The Commissioner shall grant such written approval only after he has found that:

(1) the plan of operation for the issuance of variable life insurance policies is not unsound;

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

(3) the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The Commissioner shall consider, among other things:

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

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

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

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

SECTION 2. Filing for Approval to do Business in this State.

The Commissioner may, at his discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with this Department the following information for the consideration of the Commissioner in making the determination required by Section 1, subsection (b) of this Article:

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

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

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

(d) a description of any investment advisory services contemplated as required by Section 10 of Article VI;

(e) a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies;

(f) biographical data with respect to officers and directors of the insurer on forms approved by the Commissioner; and

(g) a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

SECTION 3. Standards of Suitability.

Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the Standards of Suitability to be used by the insurer. Such Standards of Suitability shall specify that no recommendation shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or the agent making the recommendation.

SECTION 4. Use of Sales Materials.

An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive, or inaccurate.

SECTION 5. Requirements Applicable to Contractual Services.

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

SECTION 6. Reports to the Commissioner.

Any insurer authorized to transact the business of variable life insurance in this state shall submit to the Commissioner, in addition to any other materials which may be required by this regulation or any other applicable laws or regulations:

(a) an Annual Statement of the business of its separate account or accounts in such forms as may be approved by the Commissioner; and

(b) prior to its use in this state, any information furnished to applicants as provided for in Article VII; and

(c) prior to its use in this state, the form of any of the Reports to Policyholders as provided for in Article IX; and

(d) such additional information concerning its variable life insurance operations or its separate accounts as the Commissioner shall deem necessary.

Any material submitted to the Commissioner under this Section shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the Commissioner shall require the distribution of amended material.

SECTION 7. Authority of Commissioner to Disapprove.

Any material required to be filed with and approved by the Commissioner shall be subject to disapproval if at any time it is found by him not to comply with the standards established in this regulation.

Article IV: Insurance Policy Requirements.

Policy Qualification. The Commissioner shall not approve any variable life insurance form filed pursuant to this regulation unless it conforms to the requirements of this Article.

SECTION 1. Filing of Variable Life Insurance Policies.

All variable life insurance policies, and all riders, endorsements, applications and other documents which are to be attached and made a part of the policy, and which relate to the variable nature of the policy, shall be filed with the Commissioner and approved by him prior to delivery or issuance for delivery in this state.

(a) The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this regulation, the same as those otherwise applicable to other life insurance policies.

(b) The Commissioner may approve variable life insurance policies and related forms with provisions the Commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by this regulation.

SECTION 2. Mandatory Policy Benefit and Design Requirements.

Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements.

(a) Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

(b) For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid [subject to the provisions of Section 4(b) of this Article];

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

(d) Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

(e) Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

(f) The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non-forfeiture benefits, as described either in the policy or in a statement filed with the Commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with the actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non-forfeiture benefits must be at least equal to the minimum values required by Chapter 63 of Title 38 of the 1976 Code (the Standard Nonforfeiture Law for Life Insurance) for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Nonforfeiture Law of this state. If the policy does not contain an assumed investment rate, this demonstration shall be based on the maximum interest rate permitted under the Standard Nonforfeiture Law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, but are not limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

(g) The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the Commissioner.

SECTION 3. Mandatory Policy Provisions.

Every variable life insurance policy filed for approval in this state shall contain at least the following:

(a) The coverage page or pages corresponding to the cover page of each such policy shall contain:

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

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

(3) A statement describing any minimum death benefit required pursuant to Section 2(b) of this Article;

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

(5) A captioned provision that the policyholder may return the variable life insurance policy within 10 days of receipt of the policy by the policyholder, and receive a refund of premiums. Unless otherwise provided by state law, the policy may provide that the refund shall equal the total of all premium payments for the policy, or shall equal the sum of (A) the difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy and (B) the value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent.

(6) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

(b)(1) For scheduled premium policies, a provision for a grace period of not less than thirty-one days from the premium due date which shall provide that when the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(2) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the Report to Policyholders required by Section 3 of Article IX.

The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than 3 times the charges which were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep such policy in force until the next policy processing day.

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

(1) All overdue premiums with interest at a rate not exceeding the policy loan interest rate in effect for the period during and after the lapse of the policy and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding the policy loan interest rate in effect for the period during and after the lapse of the policy; or

(2) 110% of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding the policy loan interest at a rate not exceeding the policy loan interest rate in effect for the period during and after the lapse of the policy.

(d) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

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

(1) The assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

(2) The assets of such separate account shall be valued as often as any policy benefits vary, but at least monthly.

(f) A provision specifying what documents constitute the entire insurance contract under state law;

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

(h) An identification of the owner of the insurance contract;

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

(j) A statement of any conditions or requirements concerning the assignment of the policy;

(k) A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

(*l*) A provision that the policy shall be incontestable by the insurer after two years from the date of issue, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after two years from the date of issue of such increase;

(m) A provision stating that the investment policy of the separate account shall not be changed without the approval of the Commissioner of the state of domicile of the insurer, and that the approval process is on file with the Commissioner of this state;

(n) A provisions that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(1) For up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account, or

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

(*o*) If settlement options are provided, at least one such option shall be provided on a fixed basis only;

(p) A description of the basis for computing the cash value and the surrender value under the policy shall be included;

(q) Premiums or charges for incidental insurance benefits shall be stated separately;

(r) Any other policy provision required by this regulation;

(s) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation.

(t) A provision for nonforfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any nonforfeiture insurance options will not be available.

SECTION 4. Policy Loan Provisions.

Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than the following:

(a) A provision for policy loans after the policy has been in force for three (3) full years which provides the following:

(1) At least 75% of the policy's cash surrender value may be borrowed.

(2) The amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law.

(3) Any indebtedness shall be deducted from the proceeds payable on death.

(4) Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit.

(5) For scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid

within thirty-one days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following policy processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policyholder containing the information specified by Section 3 or Article IX.

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

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

(8) No policy loan provision is required if the policy is under the extended insurance nonforfeiture option.

(9) The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

(10) Amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

SECTION 5. Other Policy Provisions.

The following provision may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

(a) An exclusion for suicide within two (2) years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may also provide an exclusion for suicide within two (2) years of any increase in death benefits which result from an application of the owner subsequent to the policy issue date;

(b) Incidental insurance benefits may be offered on a fixed or variable basis;

(c) Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options:

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

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

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

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

(5) the amount of the dividend may be deposited as a variable deposit in a separate account.

(d) A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under Section 4 of this Article, except that a restriction may be imposed that no more than two consecutive premiums can be paid under this provision.

(e) A provision allowing the policyholder to make partial withdrawals;

(f) Any other policy provision approved by the Commissioner.

Article V: Reserve Liabilities for Variable Life Insurance.

(1) Reserve liabilities for variable life insurance policies shall be established under *S. C. Code* § 38-9-180 (1976) (the Standard Valuation Law) in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(2) For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee,

and shall be maintained in the general account of the insurer and shall not be less than the greater of the following minimum reserve:

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

(b) The aggregate total of the "attained age level" reserved on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue", as described in Paragraph (1), of the prior year's "attained age level" reserve on the contract, with any such "residue", increased or decreased by a payment computed on an attained age basis as described in Paragraph (2) below.

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

(2) The payment referred to in Subsection 2(b) of this Article shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any "residue", as described in Paragraph (1), of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal (A) minus (B) minus (C). The amounts of the future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

(c) The valuation interest rate and mortality table used in computing the two minimum reserves described in (a) and (b) above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

(3) For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall not be less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate.

The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

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

Article VI: Separate Accounts.

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

Section 1. Establishment and Administration of Separate Accounts.

Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to *S. C. Code* § 38-67-10 (1976).

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

(b) Such insurer shall not without prior written approval of the Commissioner employ in any material in connection with the handling of separate account assets any person who:

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

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

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

(c) All persons with access to the cash, securities, or other assets of the separate account shall be under bond in such amounts as the Commissioner may in his discretion prescribe.

(d) The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

SECTION 2. Amounts in the Separate Account.

The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

SECTION 3. Investments by the Separate Account.

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

(1) in case of transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

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

(b) The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

SECTION 4. Limitations on Ownership.

(a) A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by these regulations, would exceed 10% of the value of the assets of the separate account. The Commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

(b) No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts in the aggregate, will own more than 10% of the total issued and outstanding voting securities of such issuer. The Commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of such securities.

(c) The percentage limitation specified in Subsection (a) of this Section shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered

pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of Section 3 of this Article and other applicable portions of this regulation.

SECTION 5. Valuation of Separate Account Assets.

Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

SECTION 6. Separate Account Investment Policy.

The investment policy of a separate account operated by a domestic insurer filed under Section 2(c) of Article II shall not be changed without first filing such change with the Commissioner.

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

(2) The Commissioner may disapprove the change if he determines that the change would be detrimental to the interests of the policyholders participating in such separate accounts.

SECTION 7. Charges Against Separate Account.

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

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

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

(3) actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

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

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

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

(7) charges for incidental insurance benefits.

SECTION 8. Standards of Conduct.

Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its Board of Directors a written statement specifying the Standards of Conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such Standards of Conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17(j) under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of this Section.

SECTION 9. Conflicts of Interest.

Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

SECTION 10. Investment Advisory Services to a Separate Account.

An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(1) the person providing such advice is registered as an investment adviser under the Investment Advice Act of 1940; or

(2) the person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974, with respect to the assets of each employee benefit plan allocated to the separate account; or

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

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

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

(c) a written Standard of Conduct complying in substance with the requirements of Section B of this Article which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

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

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

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

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

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

(4) such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty days' written notice to the investment advisor.

The Commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

Article VII: Information Furnished to Applicants.

An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for such policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this Article shall be deemed to have been satisfied to the extent that a disclosure containing information required by this Article is delivered, either in the form of (1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities Exchange Commission; or (2) all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

(1) A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation. Such explanation must include notices of the provision required by Article IV, Sections 3(a)(5) and 3(f).

(2) A statement of the investment policy of the separate account, including:

(a) a description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(b) any restrictions or limitations on the manner in which the operations of the separate account are intended to be conducted.

(3) A statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence.

(4) A statement of the charges levied against the separate account during the previous year.

(5) A summary of the method to be used in valuing assets held by the separate account.

(6) A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder, and the beneficiary.

(7) Illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investments experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

Article VIII: Applications.

The application for a variable life insurance policy shall contain:

(1) a prominent statement that the death benefit may be variable or fixed under specified conditions;

(2) a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

(3) questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

Article IX: Reports to Policyholders.

Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

(1) Within thirty days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to Section (4) of Article IV under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within thirty days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty days prior to the mailing of such notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this Section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report must show the projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that: (i) planned periodic premiums, if any, are paid as scheduled; (ii) guaranteed costs of insurance are deducted; and (iii) the net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(2) Annually, a statement or statements including:

(a) a summary of the financial statement of the separate account based on the annual statement last filed with the Commissioner;

(b) the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

(c) a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the Commissioner;

(d) any charges levied against the separate account during the previous year;

(e) a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment advisor of the separate account.

(3) For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

Article X: Foreign Companies.

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by these regulations, the Commissioner to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

Article XI: Qualifications of Agents for the Sale of Variable Life Insurance.

(1) Qualification to Sell Variable Life Insurance.

(a) No person may sell or offer for sale in this state any variable life insurance policy unless such person is an agent and has filed with the Commissioner, in a form satisfactory to the Commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance.

(b) Any examination required by the Commissioner for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the Commissioner deems appropriate.

(2) Reports of Disciplinary Actions. Any person qualified in this state under this Article to sell or offer to sell variable life insurance shall immediately report to the Commissioner:

(a) any suspension or revocation of his agent's license in any other state or territory of the United States;

(b) the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance;

(c) any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(3) Refusal to Qualify Agent to Sell Variable Life Insurance: Suspension, Revocation, or Nonrenewal of Qualification. The Commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualification under this Article to sell or offer to sell variable life insurance or impose monetary penalties upon any ground that would warrant similar disciplinary arising out of the agent's sale of other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable life insurance.

PART C—SEPARABILITY

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

PART D—EFFECTIVE DATE

This Regulation shall take effect on July 1, 1988.

HISTORY: Amended by State Register Volume 12, Issue No. 7, eff July 1, 1988.

69–12.1. Replacement of Life Insurance and Annuities.

Statutory Authority: 1976 Code §§ 1-23-10, 38-3-110, 38-57-60, 38-63-10, 38-63-20, 38–63–660, 38-65-10, 38-65-20, 38-69-10, 38-69-20, 38–69–330

Section 1. Purpose and Scope

A. The purpose of this regulation is:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.

(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

(a) Assure that purchasers receive information with which a decision can be made in his or her own best interest;

(b) Reduce the opportunity for misrepresentation and incomplete disclosure; and

(c) Establish penalties for failure to comply with requirements of this regulation.

B. Unless otherwise specifically included, this regulation shall not apply to transactions involving:

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of Section 7;

(3) Group life insurance and annuities used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the director; or, when a term conversion privilege is exercised among corporate affiliates;

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) (a) Policies or contracts used to fund (i) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (ii) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer; (iii) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(b) Notwithstanding Subparagraph (a), this regulation shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(7) Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five (5) years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this regulation; or

(10) Structured settlements.

C. Registered contracts shall be exempt from the requirements of Sections 5.A.(2) and 6.B. with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

Section 2. Definitions

A. "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individual solely through mails, telephone, the Internet or other mass communication media.

B. "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

C. "Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

D. "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in Section 4.A.(5) of this regulation.

E. "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in Regulation 69–40.

F. "Policy summary," for the purposes of this regulation:

(1) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan;

(2) For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

G. "Producer," for the purpose of this regulation, shall be defined to include agents, brokers and producers.

H. "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

I. "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

J. "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

K. "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

Section 3. Duties of Producers

A. A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no," the producer's duties with respect to replacement are complete.

B. If the applicant answered "yes" to the question regarding existing coverage referred to in Subsection A, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the director. However, no approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant.

C. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

D. In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

E. Except as provided in Section 5.C., in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 4. Duties of Insurers that Use Producers

Each insurer shall:

A. Maintain a system of supervision and control to insure compliance with the requirements of this regulation that shall include at least the following:

(1) Inform its producers of the requirements of this regulation and incorporate the requirements of this regulation into all relevant producer training manuals prepared by the insurer;

(2) Provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(3) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Paragraph (2) above;

(4) Procedures to confirm that the requirements of this regulation have been met; and

(5) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance

with this regulation may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

B. Have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Insurance Department. The capacity to monitor shall include the ability to produce records for each producer's:

(1) Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(2) Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(3) Annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(4) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Subsection A.(5) of this section; and

(5) Replacements, indexed by replacing producer and existing insurer;

C. Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

D. Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in Appendix A;

E. When the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material required by Section 3.E., the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five (5) years after the termination or expiration of the proposed policy or contract;

F. Ascertain that the sales material and illustrations required by Section 3.E. of this regulation meet the requirements of this regulation and are complete and accurate for the proposed policy or contract;

G. If an application does not meet the requirements of this regulation, notify the producer and applicant and fulfill the outstanding requirements; and

H. Maintains records in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Section 5. Duties of Replacing Insurers that Use Producers

A. Where a replacement is involved in the transaction, the replacing insurer shall:

(1) Verify that the required forms are received and are in compliance with this regulation;

(2) Notify any other existing insurer that may be affected by the proposed replacement within five (5) business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five (5) business days of a request from an existing insurer;

(3) Be able to produce copies of the notification regarding replacement required in Section 3.B., indexed by producer, for at least five (5) years or until the next regular examination by the Insurance Department of a company's state of domicile, whichever is later; and

(4) Provide to the policy or contract owner notice of the right to return the policy or contract within thirty (30) days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract; such notice may be included in Appendix A or C.

B. In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of

the existing policy or contract. With regard to financed purchases, the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

C. If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to Section 3.E., the insurer may:

(1) Require with each application a statement signed by the producer that:

(a) Represents that the producer used only company-approved sales material; and

(b) States that copies of all sales material were left with the applicant in accordance with Section 3.D.; and

(2) Within ten (10) days of the issuance of the policy or contract:

(a) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with Section 3.D.;

(b) Provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(c) Stress the importance of retaining copies of the sales material for future reference; and

(3) Be able to produce a copy of the letter or other verification in the policy file for at least five (5) years after the termination or expiration of the policy or contract.

Section 6. Duties of the Existing Insurer

Where a replacement is involved in the transaction, the existing insurer shall:

A. Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five (5) years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later;

B. Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five (5) business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five (5) business days of receipt of the request from the policy or contract owner;

C. Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

Section 7. Duties of Insurers with Respect to Direct Response Solicitations

A. In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in Appendix B, or other substantially similar form approved by the director.

B. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) Provide to applicants or prospective applicants with the policy or contract a notice, as described in Appendix C, or other substantially similar form approved by the director. In these instances the insurer may delete the references to the producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the director. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall be deemed

satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(2) Comply with the requirements of Section 5.A.(2), if the applicant furnishes the names of the existing insurers, and the requirements of Sections 5.A.(3), 5.A.(4) and 5.B.

Section 8. Violations and Penalties

A. Any failure to comply with this regulation shall be considered a violation of S.C. Code Ann. 38–57–10 et seq. Examples of violations include:

(1) Any deceptive or misleading information set forth in sales material;

(2) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) The intentional incorrect recording of an answer;

(4) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

B. Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed *prima facie* evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed *prima facie* evidence of the producer's intent to violate this regulation.

C. Where it is determined that the requirements of this regulation have not been met the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in Appendix A or C.

D. Violations of this regulation shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license and monetary fines. In addition, where the director has determined that the violations were material to the sale, the insurer may be required to make restitution, restore policy or contract values and pay interest at the legal rate on the amount refunded in cash.

Section 9. Severability

If any section or portion of a section of this regulation, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this regulation, or the applicability of its provisions to other persons, shall not be affected.

Section 10. Effective Date

This regulation shall be effective ninety days after final publication in the State Register.

APPENDIX A

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer,
if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including

accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

___YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____.

I declare that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. ___(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:	Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
POLICY VALUES:	New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

APPENDIX B

NOTICE REGARDING REPLACEMENT REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

APPENDIX C

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I declare that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:	Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
POLICY VALUES:	New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?
INSURABILITY:	If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

HISTORY: Amended by State Register Volume 33, Issue No. 6, eff June 26, 2009.

69–13.3. Uniform Class and Territory Plan—Motorcycles.

The purpose of this Order is to amend portions of Order O9-74 which promulgated a uniform class plan and territory plan for motorcycle risks.

For physical damage insurance purposes, the subgroups are discontinued and the class plan is amended to provide for a rate per $100.00 of the original cost new for all physical damage coverages.

Age Group	F.O.B. List Price
Age Group 1	Original Price
Age Group 2, 3	85% Of Original F.O.B.
Age Group 4, 5	75% Of Original F.O.B.
Age Group 6	55% Of Original F.O.B.

Accordingly, the companies shall file, with this Department, premium rates for Class 01 and Class 02 as called for in Order O9-74 on the above bases for the following coverages:

(1) No Deductible Fire, Theft, and Combined Additional Coverage

(2) $50 Deductible Collision

(3) $100 Deductible Collision

(4) $250 Deductible Collision

(A broader range of deductibles may be filed in addition to the above).

This revised uniform class plan will become effective July 1, 1977. (Based on Insurance Commission designation O5-76.)

Editor's Note

This regulation was adopted December 2, 1976.

69–14. Insurance Holding Company Systems.

(Statutory Authority: 1976 Code Sections 38–3–110(2), 38–21–300, and 1–23–10 et seq.)

Section I. Forms--General Requirements.

A. Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by S. C. Code Sections 38–21–60, 38–21–70, 38–21–125, 38–21–140, 38–21–150, 38–21–225 and 38–21–250. They are not intended to be blank forms which are to be filled in. These statements filed shall contain the number 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.

B. One electronic filing for each statement (Forms A, B, C, D, E and F) including exhibits and all other papers and documents filed as a part thereof, shall be filed with the director or his designee. At least one of the copies shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

C. If an applicant requests a hearing on a consolidated basis under S.C. Code Section 38–21–90(C), in addition to filing the Form A with the director or his designee, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

D. Statements should be prepared electronically. Statements 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 normally shown in foreign currency shall be converted into United States currency.

Section II. Forms--Incorporation by Reference, Summaries and Omissions.

A. 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 such 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 or his designee which were filed within three years need not be attached as exhibits 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.

B. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the director or his designee which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

Section III. 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 shall be filed with the director or his designee a separate document:

A. identifying the information, document or report in question;

B. stating why the filing thereof at the time required is impractical; and

C. 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 or his designee within sixty days after receipt thereof enters an order denying the request.

Section IV. 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 there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matter 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.

Section V. Definitions.

A. "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.

B. "Foreign insurer" shall include an alien insurer except where clearly noted otherwise.

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 South Carolina Code Section 38–21–10 are used as defined in Section 38–21–10. Other nomenclature or terminology is defined according to Title 38 of the South Carolina Code, or industry usage if not defined by Title 38 of the South Carolina Code.

Section VI. Subsidiaries of Domestic Insurers.

The authority to invest in subsidiaries under South Carolina Code Section 38–21–30 is in addition to any authority to invest in subsidiaries which may be contained in any other provision of Title 38 of the Code.

Section VII. Acquisition of Control--Statement Filing.

A person required to file a statement pursuant to South Carolina Code Sections 38–21–60 and 38–21–70 shall furnish the required information on Form A, hereby made a part of this regulation. Such person shall also furnish the required information on Form E, hereby made a part of this regulation and described in Section X of this regulation.

Section VIII. Amendments to Form A.

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

Section IX. Acquisition of Section 38–21–60 Insurers.

A. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of South Carolina Code Section 38–21–60, the name of the domestic insurer on the cover page should be indicated as follows: "ABC Insurance Company, a subsidiary of XYZ Holding Company".

B. Where a Section 38–21–60 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.

Section X. Pre-Acquisition Notification

If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to South Carolina Code Section 38–21–60, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to South Carolina Code Section 38–21–125(C)(2). Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to South Carolina Code Section 38–21–125, 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 South Carolina Code Section 38–21–125 as set forth in South Carolina Code Section 38–21–125(B)(2). 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.

Section XI. Annual Registration of Insurers--Statement Filing.

An insurer required to file an annual registration statement pursuant to South Carolina Code Sections 38–21–130 and 38–21–140 shall furnish the required information on Form B, hereby made a part of these regulations.

Section XII. Summary of Registration--Statement Filing.

An insurer required to file an annual registration statement pursuant to Sections 38–21–130 and 38–21–140 is also required, under Section 38–21–150, to furnish information specified on Form C, hereby made a part of these regulations.

Section XIII. 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 Section 38–21–130. A registration statement may include information not required by law 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. Any authorized insurer may utilize the provisions of Sections 38–21–200 and 38–21–210 without obtaining prior approval of the director or his designee. The director or his designee, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

Section XIV. Disclaimers of Affiliation 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 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 such 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 such person should not be considered to control the subject.

B. A request for termination of registration shall be deemed to have been granted unless the Director, within thirty days after he receives the request, notifies the registrant otherwise.

Section XV. Transactions Subject to Prior Notice--Notice Filing.

An insurer required to give notice of a proposed transaction pursuant to South Carolina Code Section 38–21–250 shall furnish the required information on Form D, hereby made a part of these regulations.

A. 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 or his designee under the Insurers Rehabilitation and Liquidation Act:

(a) all of the rights of the insurer under the agreement extend to the receiver or to the director or his designee; and,

(b) all books and records will immediately be made available to the receiver or the director or his designee and shall be turned over to the receiver or the director or his designee immediately upon the request of the receiver or of the director or his designee;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the Insurers Rehabilitation and Liquidation Act; and

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Department under the Insurers Rehabilitation and Liquidation Act, and will make them available to the receiver or to the director or his designee, for so long as the affiliate continues to receive timely payment for services rendered.

Section XVI. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to South Carolina Code Section 38–21–225 shall furnish the required information on Form F, hereby made a part of these regulations.

Section XVII. 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 twelve 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 shown in the insurer's most recent annual statement;

(c) If the insurer is a life insurer, the net gain from operations as shown in the insurer's most recent annual statement;

(d) If the insurer is not a life insurer, the net income less net realized capital gains or losses as shown in the insurer's most recent annual statement; and

(e) The dividends paid to stockholders excluding distributions of the insurer's own securities.

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 South Carolina Code Section 38–21–270, each registered insurer shall report to the director or his designee all dividends and other distributions to shareholders within five business days following the declaration thereof, and at least ten days prior to the payment thereof, including the same information required by South Carolina Code Section 38–21–260 and Subsections (A)(4) (a)-(e) of this Section.

Section XVIII. Adequacy of Surplus.

The factors set forth in South Carolina Code Section 38–21–260 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 or his designee, 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 or his designee 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 or his designee will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Section XIX. Severability.

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

Section XX. Effective Date.

The amendments to this regulation shall become effective January 1, 2016.

FORM A
STATEMENT REGARDING THE ACQUISITION OF CON–TROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

By

_____
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of _____
(State of domicile of insurer being acquired)

Dated:_____, 20____

Name, Title, Address, Telephone Number and E-mail Address of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____

_____

ITEM 1. INSURER AND METHOD OF ACQUISITION.

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

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. 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, offices or employment during the last five 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 ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

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 UNDERSTANDING 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 person with whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES.

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the twelve calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. 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 twelve 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. Such statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

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

(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 Regulation 69–14.

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 South Carolina Code Sections 38–21–60 and 38–21–70, _____ 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 _____ (Name of Applicant); that (s)he is the _____ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____
(Type or print name beneath) _____

FORM B
INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

Date: _____, 20____

Name, Title, Address, Telephone Number and E-mail Address 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 home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART.

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON.

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

(a) Name.

(b) Home office address.

(c) Principal executive office address.

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

(e) The principal business of the person.

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

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

ITEM 4. BIOGRAPHICAL INFORMATION.

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 five 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:

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

(2) purchases, sales or exchanges of assets;

(3) transactions not in the ordinary course of business;

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

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

(6) leases;

(7) reinsurance agreements;

(8) dividends and other distributions to shareholders;

(9) consolidated tax allocation agreements;

(10) 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; and

(11) contributions by the Registrant to the surplus of an affiliate.

No information need be disclosed if such information is not material for purposes of South Carolina Code Section 38–21–160. Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the Registrant's admitted assets as of the previous 31st day of December shall not be deemed material, unless the Director by order or regulation provides otherwise. The description shall be in a manner as to permit the proper evaluation thereof by the Director, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS.

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS.

(a) Financial statements and exhibits should 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 such consolidated statements are prepared in the usual course of business. Other than with respect to the foregoing, such financial statements 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 or his designee. 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 such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary state and in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such 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 Form B or Regulation 69–14.

ITEM 9. FORM C REQUIRED.

A Form C, Summary of Changes to 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 South Carolina Code Sections 38–21–130 and 38–21–140, the 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 Registrant

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 _____ (Name of Company); that (s)he is the _____ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____
(Type or print name beneath) _____

FORM C
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the
State of _____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

Date: _____, 20____

Name, Title, Address, Telephone Number and E-mail Address 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 percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

SIGNATURE

Pursuant to the requirements of South Carolina Code § 38–21–150, the Registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the ____ day of _____, 20____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has fully executed the attached summary of registration statement dated _____, 20____, for and on behalf of _____ (Name of

Company); that (s)he is the _____ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of _____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

Date: _____, 20____.

Name, Title, Address, Telephone Number and E-mail Address 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 South Carolina Code Sections 38–21–250(B)(1), (2), (3), (4) or (5).

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

(c) A statement of how the transaction meets the 'fair and reasonable' standard of South Carolina Code Section 38–21–250(A)(1); and

(d) 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 nonlife 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 South Carolina Code Section 38–21–250(B)(3)(b) or a reinsurance pooling agreement or modification thereto as described by South Carolina Code Section 38–21–250(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. ALL OTHER TRANSACTIONS DETERMINED BY THE DIRECTOR TO BE MATERIAL, INCLUDING, BUT NOT LIMITED TO, REAL OR PERSONAL PROPERTY LEASES.

For leases, furnish:

(a) a brief description of the purpose of the lease.

(b) a description of the period of time during which the lease agreement is to be in effect.

(c) the aggregate payments to be made during the term of the lease.

(d) copy of the lease agreement.

ITEM 8. SIGNATURE AND CERTIFICATION.

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of South Carolina Code Section 38–21–250, _____ has caused this notice 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 fully executed the attached notice dated _____, 20____, for and on behalf of _____ (Name of Applicant); and (s)he is the _____ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the

contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____
(Type or print name beneath) _____

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

_____
Name of Applicant

_____
Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of the state of _____

Date: _____, 20____.

Name, title, address, telephone number and e-mail address of person completing this statement:

_____

_____

_____

_____

ITEM 1. NAME AND ADDRESS

State the names 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 South Carolina Code Section 38–21–125(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.

FORM F
ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of _____

By

_____
Name of Registrant/Applicant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date: _____, 20____

Name, Title, Address, Telephone Number and E-mail Address 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 South Carolina Code Section 38–21–10, 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:

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

(b) Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;

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

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

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

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

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

(h) 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 (including both the rating score and outlook);

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

(j) 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.

HISTORY: Amended by State Register Volume 13, Issue No. 4, eff April 28, 1989; State Register Volume 18, Issue No. 3, eff March 25, 1994, by Part XVIII, eff January 1, 1994; State Register Volume 34, Issue No. 3, eff March 26, 2010; State Register Volume 39, Issue No. 6, Doc. No. 4480, eff June 26, 2015.

69–15. South Carolina Deposits Required of Insurers.

Under S. C. Code Section 38–9–80 (1976), every domestic, foreign or alien insurance company, transacting or desiring to transact business in South Carolina is required to make deposits with the director or his designee in accordance with standards promulgated by him. The director or his designee is empowered to prescribe the amounts required, within the limits set forth in the statute, and he is specifically authorized to subsequently increase or decrease the amount of deposit required of any particular insurer.

The amount which an insurer is required to deposit is related to its surplus as regards policyholders (capital and surplus for stock insurers or surplus for mutual, fraternal benefit societies and reciprocal insurers), as set forth in its most recent annual statement filed pursuant to S. C. Code Section 38–13–80 (1976). Such amount is to be determined in accordance with the following table:

Surplus as Regards Policyholders	Market Value of Deposit
Under $1,000,000	$200,000
$1,000,000 or more but less than $3,000,000	$175,000
$3,000,000 or more but less than $5,000,000	$150,000
$5,000,000 or more	$125,000

The director or his designee may subsequently increase or decrease the amount of deposit required of an insurer depending upon particular circumstances, such as the current financial condition of the insurer in relation to its previous financial condition, the type or amount of business written by the insurer, the method of operation of the insurer, etc. The insurer will be notified of the amount of deposit it is required to make.

HISTORY: Amended by State Register Volume 11, Issue No. 2, eff March 1, 1987; State Register Volume 26, Issue No. 6, Part 2, eff June 28, 2002.

69–16. Motor Vehicle Damage Appraisers; General Methods by Which Such Appraisers Shall Conduct Their Business; Suspension or Revocation of an Appraiser's License.

1. As used herein, the word "appraiser" means any person who, or any partnership, association, or corporation which, practices as a business the appraising of damages to motor vehicles insured under automobile physical damage policies or in respect to third party property damage liability claims and who or which is licensed by the Commissioner to act as an appraiser.

1.1 Employees of insurance companies who are licensed as adjusters, and other persons who are licensed as adjusters and who perform loss or claim adjustments in behalf of insurers, are not required to be licensed as appraisers if their activities as appraisers are in behalf of an insurer which directly and for its own account will perform the repairs itself or which will have the repairs effected directly by a

repair shop as its agent for its own account and become responsible itself for such repairs and make payment directly to the repair shop for such repairs.

1.2 Employees of insurance companies who are licensed as adjusters, and other persons who are licensed as adjusters and who perform loss or claim adjustments in behalf of insurers, are required to be licensed as appraisers if their activities consist of making appraisals of damaged motor vehicles solely for purposes of arriving at an agreed price for repairing such motor vehicles under circumstances wherein the contract or agreement to repair the damaged motor vehicle is expected to be made between the repair shop and the owner and wherein the insurer assumes no direct responsibility for the adequacy of the repairs or payment therefor or other than inclusion of the repair shop as a joint payee on the settlement check or draft.

1.3 Before being issued a license, an applicant shall stand a written examination to determine that the applicant is qualified as an appraiser. Such examination shall be subject to, and administered in accordance with, the procedures set forth in Regulation 69-23(6)(f). Any examination fees which may be charged by an outside testing authority shall be in addition to, and not in lieu of, the annual license fee required by Code § 56-13-20.

2. Every appraiser, while engaged in his duties as such appraiser, shall carry the license issued to him by the Commissioner and shall offer to display it to an owner whose motor vehicle is being inspected, to the repair shop representative involved, or to any authorized representative of the Commissioner.

3. An appraiser may agree on a price for repairing a damaged motor vehicle only with a repair shop.

4. The appraiser shall leave a legible signed copy of his appraisal with the repair shop selected to make the repairs, which appraisal shall contain the name of the owner of the motor vehicle, the name of the insurer ordering the appraisal and its claim number, if known, the number of the appraiser's license and the proper number of the motor vehicle inspected.

4.1. All damage to the motor vehicle which is considered by the appraiser to be unrelated or old damage and which is not included in the repair price shall be clearly indicated on the appraisal.

5. If the appraiser and the repair shop fail to agree on a price for repairs, the appraiser shall not obtain a competitive estimate from another repair shop unless the owner thereof or his authorized agent shall have actually inspected the vehicle. No such competitive estimate shall be obtained by the use of photographs, telephone calls, or in any manner whatsoever other than actual, personal inspection.

6. No appraiser shall request that repairs be made in a specified repair shop.

7. Every appraiser shall reinspect damaged motor vehicles when supplementary allowances are requested by repair shops.

8. Every appraiser shall:

(1) Conduct himself in such a manner as to inspire public confidence by fair and honorable dealing;

(2) Approach the appraisal of damaged motor vehicles without prejudice against, or favoritism toward, any party involved in order to make fair and impartial appraisals;

(3) Disregard any efforts on the part of others to influence his judgment in the interest of any of the parties involved;

(4) Prepare an independent, objective appraisal of damage.

8.1 No appraiser shall:

(1) Receive directly or indirectly any gratuity or consideration in connection with his appraisal services from any person except his employer or, if self-employed, his customer;

(2) Traffic in, or acquire for himself, his employer, or any relative of either, any salvage if such salvage is obtained in any way as a result of, or incident to, appraisal services rendered by him.

9. The Commissioner may suspend or revoke the license issued to an appraiser or refuse to renew such license upon his finding that any such appraiser has violated any law involving moral turpitude,

or has violated, or failed to comply with, any law of this State relating to his duties or conduct as an appraiser or any provision of this Regulation.

HISTORY: Amended by State Register Volume 8, Issue No. 7, eff July 27, 1984.

69–17. Advertising of Accident and Health Insurance.

(Statutory Authority: 1976 Code § 38-3-60(1))

Section 1. Purpose. The purpose of these rules is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident, health, and accident and health insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance consumer of a policy of such insurance offered through various advertising media or through the mails.

Section 2. Applicability.

A. These rules shall apply to any accident, health, or accident and health insurance "advertisement," as that term is hereinafter defined, intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent or broker as those terms are defined in the Insurance Code of this State, or these rules.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.

Section 3. Definitions.

A. An advertisement for the purpose of these rules shall include:

1. printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio script, TV script, billboards and similar displays; and

2. descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

3. prepared sales talks, presentations and material for use by agents, brokers and solicitors.

B. "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

C. "Insurer" for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the Insurance Code of this State and is engaged in the advertisement of a policy as "policy" is herein defined.

D. "Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

E. "Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

F. "Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

Section 4. Method of Disclosure of Required Information. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

Section 5. Form and Content of Advertisements.

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. An advertisement is misleading if it omits any material information necessary to render it not misleading.

Section 6. Advertisements of Benefits Payable, Losses Covered or Premiums Payable.

A. Deceptive Words, Phrases or Illustrations Prohibited

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

2. No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the coverage or otherwise renders the advertisement misleading or deceptive.

3. An advertisement shall not contain descriptions of a policy limitation, exception or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder," or stating "even pre-existing conditions are covered after two years"; nor shall such advertisement be so worded as to imply that provisions required by statute, such as, but not limited to, the ten-day inspection period provision or the two year incontestability provision, were voluntarily adopted by the insurer or differ from similar provisions in the policies of other insurers. Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

4. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

5. No advertisement of a hospital or other similar facility confinement shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement; except that a statement of the benefit payable on a daily basis may be followed immediately by a statement of no greater prominence setting forth the monthly or weekly benefit amounts. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

6. No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

7. An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY".

8. An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan", or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

B. Exceptions, Reductions and Limitations

1. When an advertisement refers to either dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

2. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

3. An advertisement shall not use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions".

C. Pre-Existing Conditions

1. An advertisement which is subject to the requirements of Section 6B shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used.

2. When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue". If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question (or statement) substantially as follows:

> Do you understand that this policy will not pay benefits during the first ____ Year(s) after the issue date for a disease or physical condition which you now have or have had in the past?—YES

Section 7. Necessity for Disclosing Policy Provisions Relating To Renewability, Cancellability and Termination. When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

Section 8. Testimonials or Endorsements by Third Parties.

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

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement". This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the entity making such endorsement or testimonial has any direct or indirect financial interest in the insurance by way of commission; retrospective plan rate or commission adjustment; profit sharing allowance; policy dividend; or any similar refund, return or participation of whatsoever nature, such fact shall be fully disclosed.

D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

Section 9. Use of Statistics.

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous", or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

Section 10. Identification of Plan or Number of Policies.

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

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

Section 11. Disparaging Comparisons and Statements. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

Section 12. Jurisdictional Licensing and Status of Insurer.

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

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

Section 13. Identity of Insurer.

A. The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any 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 which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the Federal government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

Section 14. Group or Quasi-Group Implications. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

Section 15. Introductory, Initial or Special Offers.

A.1. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special", "limited", or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

2. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

3. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

4. The phrase "a particular insurance product" in Paragraph (2) of this section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both

the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

C. Special awards, such as a "safe drivers' award" shall not be used in connection with advertisements of accident or accident and sickness insurance.

Section 16. Statements About an Insurer. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

Section 17. Enforcement Procedures.

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance. Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these rules must file with this Department, with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this State as implemented and interpreted by these rules.

Section 18. Severability Provision. If any Section or portion of a Section of these rules or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Section 19. Filing for Prior Review. The Commissioner may, in his discretion, require the filing with this Department, for review prior to use, of all direct response material, or all or any of such material issued by certain insurers upon his finding that such insurers have been named in an excessive number of complaints made to the Department, or of all such material relating to a particular line or type of insurance, such as, but not limited to, accident policies, cancer policies, or Medicare Supplement policies. All such advertising material required to be filed by any such insurer or insurers shall be so filed with the Department not less than 30 days prior to the date the insurer desires to use the advertisement unless the Commissioner consents to a shorter time for the filing of such material prior to its use.

Section 20. Subsection A of Section 17 of this Regulation shall take effect immediately, and all other provisions of the Regulation shall take effect July 1, 1974.

69–18. Title Insurance.

Section 1. *Purposes.* The within Regulation is predicated upon recognition of the fact that, as presently constituted, the title insurance business is characterized by reverse competition, which is to say that competition among title insurers regularly takes the form of insurers vying with each other for the favor of mortgage lenders, attorneys, or others who control, or who may control, the placement of the title insurance with title insurers. Such reverse competition tends to increase title insurance premiums or to prevent lowering of such premiums in order that greater commissions or other allowances may be paid to agents or mortgage lenders for such business as a means of obtaining the placement of business controlled by the agent with the insurer paying the highest commissions. In addition, other inducements are made to mortgage lenders, attorneys, or others who control, or who may control, such business by title insurers as a means of securing the placement of such business with the insurers offering the inducements. The reciprocal of such inducements is that mortgage lenders or others have resorted to practices which constitute or border upon coercion, intimidation, or boycott in

order to obtain or increase their participation in the title insurance premiums. Manifestly, reverse competition works to the detriment, rather than in favor of, the consumer who is called upon to pay the title insurance premiums, and this reverse competition operates to thwart normal economic forces which would otherwise tend to lower title insurance premiums.

(a) Inasmuch as acts of coercion, boycott, or intimidation are not saved by the McCarran-Ferguson Act from application of the Federal antitrust and Federal Trade Commission laws, even though such acts relate to the business of insurance, this State is in danger of being ousted of its regulatory authority over title insurance if prevalent practices and abuses are suffered by this State to continue.

(b) Title insurers which abstain from the payment of excessive commissions or the offering of such inducements either because they deem the same to be morally wrong, or because they fear Federal prosecution, cannot operate or expand their operations within this State because of the competitive disadvantage which they suffer through refusing to offer such inducements.

Section 2. *Unlawful Rebates and Inducements.* No title insurer or other person controlled by it shall pay or offer to pay, either directly or indirectly, any referral commission or fee or any part of the premiums for title insurance or any other consideration whatsoever as an inducement for or as compensation on any title insurance business in connection with which a title insurance policy is issued to any of the following:

(a) Any owner or prospective owner or lessee or prospective lessee of real property or any interest therein.

(b) Any obligee or prospective obligee of an obligation secured or to be secured either in whole or part by real property or any interest therein.

(c) Any person who is acting as or who is in the business of acting as agent, representative, attorney, or employee of any of the persons described in (a) or (b); provided, however, that this subdivision shall not be deemed to preclude payment by a title insurer of normal commission to an agent, representative or attorney of any of the persons described in the said subdivisions (a) or (b), but who is not the employee of any such person, except that if any such person entitled to receive and receiving commission hereunder stands in a fiduciary relation to any of the persons described in subdivisions (a) or (b), he must disclose in writing to such person the rate or amount of the commission to be received; further provided, that the commission received from the insurer may not be shared either directly or indirectly with any other person except a duly licensed agent who is not in the employment or under the control of any of the persons described in subdivisions (a) or (b) hereof.

(1) The rule is based, in part, upon recognition of the fact that the agent, representative or attorney of the purchaser or seller paying for the title insurance policy stands in a fiduciary or quasi-fiduciary relationship with such purchaser or seller and that the receipt by him of money or other economic benefit beyond that which such agent, representative or attorney is entitled to as normal commission for services rendered would be inconsistent with his fiduciary relationship in selecting the title insurance for the purchaser or seller. Given a fair disclosure of the rate or amount of such commission to such purchaser or seller, the payment of reasonable agents' commissions is not inappropriate provided there is no division of such commissions in a manner which constitutes a rebate or a benefit to the lender. It is reasonable to assume that when there is no possibility of an unearned and undisclosed material personal benefit or rebate to the said agent, representative or attorney of the purchaser or seller, he would either make no recommendation as to the title insurer or would recommend a listing of title insurers known to be competitive in terms of price or service in order to enhance his own business reputation and competitive position.

(i) In connection with any such disclosure in writing pursuant to paragraph (1) of this subsection, the agent, representative or attorney shall inform the purchaser or seller in writing of his right to choose the title insurer notwithstanding the recommendation of any such agent, representative, or attorney. Such writing shall also fairly and fully inform the purchaser of the limitations of the mortgagee-type title insurance policy as regards protection of the owner's separate interest in the property and shall inform him as respects the availability and cost of an owner's-type policy from the title insurer. If the particular title insurer represented by the said agent, representative or attorney does not provide owner's-type coverage, the written disclosure must state that many insurers provide both mortgagee-type policies and owner's-type policies.

(2) Any of the following activities by a title insurer will be deemed to constitute an unlawful rebate or inducement, but the listing of such activities is not to be construed as exhaustive of such unlawful activities and it may not be inferred that an omission from the listing constitutes a justification for engaging in a particular practice which has not been specifically listed. The term "such person" as used herein refers to any person described in subdivisions (a), (b), or (c) of Section 2:

(A) Charging either more or less than the scheduled rate for a policy of title insurance.

(B) Furnishing a preliminary title report, printed copies of covenants, conditions, and restrictions, or plats, maps, and like materials without charge to any such person. Any charge made for any such reports or materials must have a reasonable relation to the cost of production and the same shall be the same to all persons.

(C) Furnishing reports containing publicly recorded information, appraisals, estimates of income production potential, information kits or similar packages containing information about one or more parcels of real property helpful to any such person without making a charge that is commensurate with the actual cost of the work performed and the material furnished.

(D) Delaying the issuance of a policy beyond the close of escrow and crediting or deferring the charge therefor in order to qualify a later transaction for a lower rate.

(E) Providing, or offering to provide, either directly or indirectly a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by such lending institution to any such person or for the express or implied purpose of influencing the placement or channeling of title insurance business by such lending institution.

(F) Paying for, or offering to pay for, the fees or charges of an outside professional, such as an attorney, engineer, appraiser, or surveyor, whose services are required or useful by any such person to structure or complete a particular transaction.

(G) Paying for, or offering to pay for, the salary or any part of the salary of an employee of any such person, or paying for, or offering to pay for, the salary or any part of the salary of a relative of any such person.

(H) Paying, or offering to pay, any fee to any such person for making an inspection or appraisal of property whether such fee bears a reasonable relationship to the services performed or not.

(I) Furnishing or offering to furnish, paying for or offering to pay for, furniture, office supplies, telephones, equipment or automobiles to any such person, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of the aforementioned items.

(J) Paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by any such person.

(K) Renting, or offering to rent, space from any such person, regardless of the purpose, at a rent which is excessive when compared with rents for comparable space in the geographic area, or paying, or offering to pay, rent based in whole or in part on the volume of title insurance business generated by any such person.

(L) Paying for, or offering to pay for, entertainment, vacations, business trips, convention expenses, travel expenses, membership fees, registration fees, lodging or meals on behalf of any such person, directly or indirectly or supplying letters of credit, credit cards or any such benefits to any such person for any purpose whatsoever.

(M) Paying for or furnishing, or offering to pay for or furnish, any brochures, billboards, or advertisements appearing in newspapers, on the radio, or on television, or other advertising or promotional material published or distributed by or on behalf of any such person whether used in connection with the promotion, sale, or encumbrance of real property or not.

(N) Paying for or furnishing, or offering to pay for or furnish, any business form to any such person other than a form regularly used in the conduct of the title insurer's business and furnished solely for its convenience in the conduct of its normal business.

(O) Buying from or selling to, or exchanging with, or offering to buy from, sell to, or exchange with any such person, shares of stock in the title insurer or any business concern controlling or controlled by or affiliated with the title insurer except for purchases or exchanges made through a general public offering.

Section 3. *Rates, Rating Plans, and Rating Organizations.* On or before the one hundred twentieth day following the effective date of this Regulation, title insurers shall file, or cause to be filed in their behalf by a duly constituted and qualified rating organization, their rates for title insurance policies together with the rating plans and rating systems used by them in the making of rates; and such rating plans and rating systems shall be so structured as to produce rates which are adequate, not excessive and not unfairly discriminatory. Such rates whether made and filed by the insurer independently or in its behalf by a lawfully constituted rating organization shall be adequate, not excessive, and not unfairly discriminatory and shall be approved by the Chief Insurance Commissioner prior to their use.

69–20. Campus Life Insurance.

Complaints and abuses related to life insurance sold on or around the campuses of our universities and colleges have grown to intolerable proportions bringing into disrepute not only such campus life insurance but all life insurance. In particular, practices surrounding the making and acceptance of notes signed by the student-insured for the first-year premium with payment of such notes to be made out of the cash values of the policy at some future time has given rise to constant misunderstandings and has constituted a vehicle for fraudulent, deceptive, or misleading practices. In particular, failure to disclose adequately and clearly that lapse of the policy for any reason renders the note due and payable immediately has constituted a constant source of friction and complaint.

Accordingly, we propose to issue the following regulations relating to the sale and marketing of campus life insurance:

1. Purposes. The purpose of these regulations is to prohibit false, deceptive or misleading practices in respect to the marketing of campus life insurance and so to regulate the sale or attempted sale of campus life insurance as to prevent such practices in connection with the sale or attempted sale of such insurance.

2. Definition. "Campus Life Insurance" is hereby defined to mean any program of life insurance, including supplemental benefits, such as waiver of premium, accidental death, or like benefits, sold to university or college students under such circumstances that the premium, or any part thereof, for the first or any following year of coverage is deferred or is made through the execution of a promissory note or similar instrument.

3. Applicability of Premium Service Company Act or other laws. Nothing herein shall be deemed to supersede the Premium Service Company Act, nor any other law otherwise applicable, nor to suggest that the Premium Service Company Act, or other law, is not applicable to the financing of premiums for campus life insurance.

4. Registration and Approval. (1) No insurer conducting or proposing to conduct a campus life insurance program, and no agent, broker, or other person conducting or proposing to conduct such a program shall do so, or continue to do so, unless such insurer, agent, broker, or other person shall first file with the Chief Insurance Commissioner (Commissioner) notice of intent to conduct such program and receive from the Commissioner his approval. Such approval shall not be granted by the Commissioner unless the insurer, agent, broker, or other person has filed with him a copy of every promissory note or other security instrument, brochure, pamphlet, circular, flyer, leaflet or other advertising or sales piece together with a copy of every planned or prepared oral presentation to be made in connection with the sale or attempted sale of campus life insurance; nor shall the Commissioner grant such approval unless he finds all of such material to be complete, fair, unambiguous, and free from any tendency to mislead, deceive or confuse the student to whom it is to be addressed.

(2) No such insurer, agent, broker, or other person conducting or proposing to conduct a campus life insurance program on or about the campus of any university or college shall do so or continue to do so unless it or he shall first register with the president, dean, or other authorized official of such university or college and provide such official with evidence of the Commissioner's approval. Nothing herein shall be deemed to limit or impair the right of any authorized official of

a university or college to impose other or further limitations in respect to sales on campus or to prohibit such sales in accordance with the rules of the particular institution.

(3) The Commissioner may, after due notice and public hearing, withdraw any such approval previously granted by him for any reason which would have justified his refusal to grant approval had the reason then existed or been known; and upon withdrawal of such prior approval, the Commissioner shall so advise the president, dean or other authorized official of every such university or college.

5. Limitations Upon Financing Agreements. No insurer and no agent, broker, or other person representing any insurer shall accept, transmit, or otherwise assist in the preparation or transmission of any promissory note or other instrument, agreement or document in connection with campus life insurance under which any holder, including the payee, may claim to be a holder in due course without notice, and no such holder acquiring any such note, instrument, agreement, or document in connection with the sale and purchase of campus life insurance shall be deemed a holder in due course without notice. Every assignment of such a note, instrument, agreement or document shall be with recourse against the assignor and shall make express reference to the fact that it is subject to this Regulation. It is the purpose of this Regulation to render any such note, instrument, document, or agreement accepted and transmitted in connection with the sale and purchase of campus life insurance subject to all defenses existing between the original parties and to imbue every such note, instrument, agreement or document taken in connection with, or related to, an application for life insurance completed or accepted in South Carolina covering a life then situate in South Carolina subject to the provisions of this Regulation and the public policy of this State.

6. Prohibited Practices. (1) No insurer, agent, broker, or other person representing any insurer shall sell, attempt to sell, or participate in any way in the sale or attempted sale of any policy or contract of campus life insurance unless it or he has first complied with all of the requirements of this Regulation.

(2) No insurer, agent, broker, or other person representing any insurer shall sell, attempt to sell or participate in any way in the sale or attempted sale of any policy or contract of campus life insurance unless the student making application for such insurance is at the time of such application actually a student who in the absence of course failure or withdrawal would be expected to complete his degree within 18 months, or a graduate student at the university or college. The confirmation of two or more occurrences by the Commissioner that the applicant for campus life insurance was not, at the time, such a student or graduate student shall constitute sufficient grounds for withdrawing any approval granted under Section 4 of this Regulation in respect to the insurer, agent, broker, or other person involved in such two or more occurrences.

(3) No insurer, agent, broker, or other person representing any insurer shall accept any application for campus life insurance unless the applicant for such insurance shall himself pay in cash or its equivalent not less than 10 percent, or $20, whichever is the lesser, of the first year's premium for such insurance; and no such insurer, agent, broker, or other person shall lend, extend credit for, or in any other manner whatsoever defer or forgive such payment. Any violation of this section shall be sufficient grounds for the withdrawal of any approval previously granted the affected insurer, agent, broker, or other person under Section 4 of this Regulation in addition to any other penalty which such insurer, agent, broker or other person may incur as a result of such violation. Any approval withdrawn by the Commissioner after due notice and hearing on account of the violation of this Section shall not be restored for a period of at least twenty-four months from the effective date of such withdrawal.

(4) No insurer, agent, broker, or other person transacting a campus life insurance business shall finally consummate any such contract or policy of campus life insurance unless it or he shall first deliver or cause to be delivered a disclosure statement, in form approved by the Commissioner, fully, fairly and unambiguously stating the terms of the policy or contract, including, but not limited to, any exclusions of, or limitations upon coverage, and fully, fairly, and unambiguously disclosing the terms, including, but not limited to, the effective rate of interest, in connection with any promissory note, instrument, agreement or other document related to the premium for such policy or contract. Without limitation upon the generality, such disclosure statement shall include a brief description of every supplemental benefit, if any, contained in the policy, the amount of premium for each such supplemental benefit and the time period over which such premium is to

be paid in respect to any such benefit. The disclosure statement shall require the signature of the applicant and shall make provision for the absolute right of rejection of the policy or contract of campus life insurance within 10 days of the applicant's receipt of such disclosure statement and repayment to him of any amount paid by him in respect to any premium for such insurance. (a) If a disclosure statement is delivered in person by any agent, broker, or other person representing the insurer, no confirmation of the transaction through signature by the applicant shall be valid unless an interval of not less than three days shall separate the delivery of the disclosure statement and its redelivery to such agent, broker, or other person. Any violation of this provision shall be sufficient grounds for the withdrawal of any approval granted pursuant to Section 4 of this Regulation in respect to such agent, broker, or other person found by the Commissioner, upon due notice and hearing, to have participated in such violation.

7. Records and Inspections. Every insurer, agent, broker, or other person representing an insurer transacting a campus life insurance business shall maintain and keep for a period of not less than three years, records of such business including all sales and advertising material, copies of applications, promissory notes, instruments, agreements or other documents, disclosure statements and like relevant material in respect to each transaction and all such records shall be open to the Commissioner or his representative at all reasonable times. Such records need not be duplicatively and separately maintained by an insurer and its representative but it is the responsibility of the insurer to inform the Commissioner where such records are being maintained. In the event such records are maintained without this State, the Commissioner may upon his own or the complaint of another person inspect and examine such records in person or through his designated representative and the reasonable expenses of such inspection and examination shall be borne by the insurer or other person maintaining such records and such expenses shall be collected by the Commissioner for the general revenues of the State. Failure or refusal by any person having custody of such records to open them, upon demand, to inspection by the Commissioner or his designated representative shall be sufficient grounds for the withdrawal of any approval previously granted by the Commissioner pursuant to Section 4 of this Regulation upon the Commissioner's finding, after due notice and hearing, of such failure or refusal.

8. Effective Date. This Regulation shall become effective 120 days after its filing with the Secretary of State, except that its provisions shall become effective immediately and be controlling in respect to any forms, advertising or other material filed with the Commissioner for approval.

69–22. Health Maintenance Organizations.

Section I. Definitions.

Unless the context otherwise requires, the following definitions shall apply as the terms are used in both this regulation and Chapter 33 of Title 38 of the 1976 South Carolina Code, as amended (the Health Maintenance Organization Act of 1987):

A. "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services. "Basic health care services" does not include dental services, mental health services, or services for alcohol or drug abuse, although a health maintenance organization may at its option elect to provide these services in its coverage.

B. "Contractholder" means a person or entity consisting of employees or eligible persons which has entered into a group contract with a health maintenance organization for the provision of specified health care services to its eligible employees or eligible persons.

C. "Commissioner" means the Chief Insurance Commissioner.

D. "Copayment" or "deductible" means the amount specified in the evidence of coverage that the enrollee shall pay directly to the provider for covered health care services, which may be stated in either specific dollar amounts or as a percentage of the provider's usual or customary charge.

E. "Department" means the Department of Health and Environmental Control.

F. "Eligible dependent" means any member of a subscriber's family who meets the eligibility requirements set forth in Subsection D of Section III of this regulation.

G. "Emergency care services" means:

1. Within the service area: covered health care services rendered by affiliated or non-affiliated providers under unforeseen conditions that require immediate medical attention. Emergency

care services within the service area shall include covered health care services from non-affiliated providers only when delay in receiving care from the health maintenance organization could reasonably be expected to cause severe jeopardy to the enrollee's condition.

2. Outside the service area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the health maintenance organization's service area.

H. "Enrollee" or "member" means an individual who is enrolled in a health maintenance organization.

I. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which he is entitled.

J. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group.

K. "Health care services" means any services included in the furnishing to any individual of medical or dental care or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.

L. "Health maintenance organization" means any person that undertakes to provide or arrange for basic health care services to enrollees for a fixed prepaid premium.

M. "Health professional" means any professional engaged in the delivery of health care services who is licensed, and practicing within the scope of such a license, where such licensing is required by state law.

N. "Hospital" means a duly licensed institution which provides general and specialized inpatient medical care. The term "hospital" shall not include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

O. "Individual contract" or "nongroup contract" means a contract for health care services issued to and covering an individual or a family.

P. "Medical necessity" or "medically necessary" means appropriate and necessary services as determined by any provider affiliated with the health maintenance organization which are rendered to an enrollee for any condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience.

Q. "Out-of-area services" means the health care services that a health maintenance organization covers when its enrollees are outside of the service area.

R. "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

S. "Physician" means a duly licensed doctor of medicine or osteopathy practicing within the scope of such a license.

T. "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to members; initiates their referral for specialist care and maintains continuity of patient care.

U. "Provider" means any physician, dentist, hospital, pharmacist, or other person properly licensed, where required, to furnish health care services.

V. "Service area" means the geographical area as approved by the Commissioner within which the health maintenance organization provides or arranges for health care services that are available and accessible to enrollees.

W. "Skilled nursing facility" means a facility that is operated pursuant to law and primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician.

X. "Subscriber" means the individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the health maintenance organization and who is in fact enrolled in the health maintenance organization.

Y. "Supplemental health care services" means any health care services other than basic health care services.

Section II. License Requirements.

A. Health Maintenance Organizations.

1. No person may undertake to provide or arrange for any basic health care service for a fixed prepaid premium in this State without first obtaining a certificate of authority from the Commissioner to transact business as a health maintenance organization.

2. No health maintenance organization chartered, organized and existing under the laws of the State will be licensed by the Commissioner unless it meets all requirements of law and this regulation and it maintains its records, accounts, home office and principal place of business in this State.

3. No health maintenance organization chartered, organized and existing under the laws of another state will be licensed by the Commissioner unless it meets all requirements of law and this regulation and the Commissioner has determined that:

a. the applicant is registered as a foreign corporation to do business in this State;

b. the applicant is subject to regulation of its financial condition in its state of domicile, including regular financial examination not less frequently than once every three years; and

c. the applicant complies with such conditions as the Commissioner may prescribe with respect to the maintenance of books, records, accounts and facilities in this State.

B. Agents.

1. An "agent" means a person who is appointed or employed by a health maintenance organization and who engages in solicitation of membership in the health maintenance organization. The term "agent" does not include an employee of an employer, union or other contractholder to whom a master subscriber contract has been issued whose duties include enrolling members in the health maintenance organization on behalf of the employer, union or other contractholder.

2. No person may act as an agent on behalf of a health maintenance organization in this State unless he has been licensed by the Commissioner as an accident and health insurance agent for that health maintenance organization. No health maintenance organization may accept members solicited by, or otherwise transact business through, persons who are not licensed by the Commissioner as accident and health insurance agents for the health maintenance organization. Salaried employees of the health maintenance organization are exempt from licensing requirements.

Section III. Requirements for Contracts and Evidence of Coverage.

A. Each subscriber shall be entitled to a contract or evidence of coverage as approved by the Commissioner. A contract or evidence of coverage shall be delivered or issued for delivery to a subscriber or to the contractholder for delivery to the subscriber within a reasonable time after enrollment, but not more than thirty (30) days from the later of the effective date of coverage or the date on which the health maintenance organization is notified of enrollment.

B. Health Maintenance Organization Information.

1. The contract and evidence of coverage shall contain the name, address and telephone number of the health maintenance organization, and where and in what manner information is available as to how services may be obtained.

2. A toll-free or local phone number within the service area for calls, without charge to members, to the health maintenance organization's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for member services, problems or questions.

C. Entire Contract.

1. The contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties.

2. No portion of the charter, bylaws or other document of the health maintenance organization shall be part of such a contract unless set forth in full in the contract or attached thereto.

D. Term of Coverage.

1. The contract shall contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined.

2. The contract shall contain the time and date or occurrence upon which coverage will terminate.

E. Eligibility Requirements.

1. The contract and evidence of coverage shall contain eligibility requirements indicating the conditions that must be met to enroll as a subscriber or eligible dependent, the limiting age for subscribers and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children.

2. The definition of an eligible dependent shall as a minimum include:

a. the spouse of the subscriber;

b. an unmarried dependent child of the subscriber who has not reached age 19;

c. an unmarried dependent child of the subscriber age 19 or over, who is both incapable of self support because of intellectual disability, mental illness or physical incapacity which began before the child reached age 19, and chiefly dependent upon the subscriber for support and maintenance; or

d. an unmarried dependent child of the subscriber age 19 through 22 who is attending a recognized college or university, trade or secondary school on a full-time basis.

3. The definition of a dependent child shall as a minimum include children who are:

a. related to the subscriber as either a natural child, a legally adopted child, a stepchild, a foster child, or a child under legal guardianship; or

b. any other child residing in the subscriber's household and who qualifies as a dependent of the subscriber or the subscriber's spouse under the United States Internal Revenue Code and federal tax regulations.

4. All contracts and evidences of coverage shall provide coverage for a newly-born child of the subscriber from the moment of birth. Medically diagnosed congenital defects and birth abnormalities shall be treated the same as any other illness or injury for which coverage is provided. The contract and evidence of coverage may require that notification of birth of a newborn child and payment of any required premium must be furnished to the health maintenance organization within thirty-one (31) days after the date of birth in order for such coverage to have become effective and to continue beyond such thirty-one (31) day period.

F. Benefits and Services within the Service Area. The contract and evidence of coverage shall contain a specific description of benefits and services available within the service area.

G. Emergency Care Services. The contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies twenty-four (24) hours a day, seven (7) days a week, including disclosure of any restrictions on emergency care services. No contract or evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

H. Out-of-Area Benefits and Services. The contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area.

I. Copayments, Deductibles, Limitations and Exclusions. The contract and evidence of coverage shall contain a description of any copayments, deductibles, limitations or exclusions on the services, kind of services, benefits, or kind of benefits to be provided, including any copayments, deductibles, limitations or exclusions due to preexisting conditions, waiting periods or an enrollee's refusal of treatment.

J. Cancellation or Termination. The contract and evidence of coverage shall contain the conditions upon which cancellation or termination may be effected by the health maintenance organization or the subscriber.

K. Renewal. The contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

L. Reinstatement. The contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to reinstatement.

M. Grace Period.

1. The contract and evidence of coverage shall provide for a grace period of not less than thirty-one (31) days for the payment of any premium except the first, during which coverage shall remain in effect if payment is made during the grace period.

2. During the grace period, the health maintenance organization shall remain liable for providing the services and benefits contracted for, the contractholder shall remain liable for the payment of the premium for the time coverage was in effect during the grace period, and the subscriber shall remain liable for any copayments or deductibles owed.

N. Claims. The contract and evidence of coverage shall contain procedures for filing claims that include:

1. any required notice to the health maintenance organization;

2. if any claim forms are required, how, when and where to obtain and submit them;

3. any requirements for filing proper proofs of loss;

4. any time limit on payment of claims;

5. notice of any requirement for resolving disputed claims including arbitration; and

6. a statement of restrictions, if any, on assignment of sums payable to the enrollee by the health maintenance organization.

O. Complaint System and Arbitration. The contract and evidence of coverage shall contain a description of the health maintenance organization's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract, including any requirements for arbitration.

P. Conversion of Coverage.

1. The contract and evidence of coverage shall contain a conversion provision which provides that each enrollee has the right to convert coverage to an individual health maintenance organization contract or to a policy of health insurance issued by a licensed insurer on a form previously approved by the Chief Insurance Commissioner in the following circumstances:

a. upon termination of eligibility for coverage under a group or individual contract; or

b. upon termination of the group contract.

2. To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment within the time period and in the manner prescribed by Section 38–71–770. The enrollee shall be entitled to the same right of continuation of coverage as provided therein.

3. A conversion contract shall not be required to be made available if:

a. the enrollee's termination of coverage occurred for any of the reasons listed in Subparagraphs 1.a.(1), (2), or (3) of Subsection B of Section IV of this regulation;

b. the enrollee is covered by or is eligible for benefits under Medicare, Title XVIII of the United States Social Security Act;

c. the enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under state or federal law;

d. the enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group;

e. the enrollee is covered for similar benefits by an individual policy or contract; or

f. the enrollee has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

4. As a minimum, the conversion contract shall provide basic health care services if conversion is to a health maintenance organization contract or shall provide benefits meeting the minimum requirements of Section 38–71–770, if conversion is to a policy of health insurance.

5. Coverage shall be provided without requiring evidence of insurability and shall not impose any preexisting condition limitations or exclusions as described in Subsection A of Section IV other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of the enrollee's coverage under the prior contract.

Q. Group Contract Discontinuance and Replacement. The provision of S. C. Code Section 38–71–760 governing discontinuance and replacement of coverage are applicable to group health maintenance organization contracts.

R. Coordination of Benefits.

1. The contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other health insurers and health maintenance organizations in South Carolina.

2. Any provisions or rules for coordination of benefits established by a health maintenance organization shall not relieve a health maintenance organization of its duty to provide or arrange for a covered health care service to any enrollee because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs.

S. Right to Examine Contract.

1. An individual contract shall contain a provision stating that a person who has entered into an individual contract with a health maintenance organization shall be permitted to return the contract within ten (10) days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason.

2. If the contract is returned to the health maintenance organization or to the agent through whom it was purchased, it is considered void from the beginning.

3. However, if services are rendered or claims are paid for such person by the health maintenance organization during the ten-day examination period, the person shall not be permitted to return the contract and receive a refund of the premium paid.

T. Subrogation/Injuries Caused by Third Parties. Any provisions concerning subrogation for injuries caused by third parties shall conform to the requirements of S. C. Code Section 38–71–190 (1976), as amended.

U. Conformity with State Law. Any contract and evidence of coverage that contains any provision not in conformity with the Health Maintenance Organization Act of 1987 shall not be rendered invalid but shall be construed and applied as if it were in full compliance with this regulation and the Health Maintenance Organization Act of 1987.

Section IV. Prohibited Practices.

A. Preexisting Conditions.

1. A health maintenance organization contract may contain a provision limiting coverage for preexisting conditions.

2. The preexisting conditions must be covered no later than twelve months without medical care, treatment, or supplies ending after the effective date of the coverage or twelve months after the effective date of the coverage, whichever occurs first.

3. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended no more than twelve months prior to the effective date of a person's coverage".

B. Termination of Coverage.

1. Cancellation.

a. No health maintenance organization shall cancel coverage of services provided an enrollee under an individual or group health maintenance organization contract except for one or more of the following reasons:

(1) failure to pay the amounts due under the contract;

(2) fraud or material misrepresentation in enrollment or in the use of services or facilities;

(3) material violation of the terms of the contract;

(4) failure to meet the eligibility requirements under a group contract, provided that a conversion option is offered.

b. However, coverage shall not be cancelled, terminated or nonrenewed on the basis of the status of the enrollee's health nor on the fact that the enrollee has exercised his rights under the health maintenance organization's complaint system by registering a complaint against the health maintenance organization.

3. Nonrenewal.

a. Group Contracts. No health maintenance organization shall nonrenew a group health maintenance organization contract except on the anniversary date of the contract.

b. Individual Contracts. No health maintenance organization shall nonrenew coverage of services provided an enrollee under an individual health maintenance organization contract unless it has received prior approval from the Commissioner, upon such terms as he deems just, to nonrenew all individual health maintenance organization contracts in this State.

4. No health maintenance organization shall cancel, terminate or nonrenew an enrollee's coverage for services provided under a health maintenance organization contract without giving the enrollee or contractholder written notice of termination which shall be effective at least thirty-one (31) days from the date of mailing or, if not mailed, from the date of delivery and which shall include the reason for termination. For termination due to nonpayment of premium, the grace period as required in Subsection M of Section III of this regulation shall apply. No written notice of termination shall be required to be given for termination due to nonpayment of premium.

5. No health maintenance organization that provides in the contract and evidence of coverage, that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children shall terminate the coverage of such child if the child is and continues to be both:

a. incapable of self support because of intellectual disability, mental illness or physical incapacity, and

b. chiefly dependent upon the subscriber for support and maintenance.

6. Proof of such incapacity and dependency shall be furnished to the health maintenance organization by the subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as reasonably required by the health maintenance organization, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

C. Unfair Discrimination.

1. No health maintenance organization shall unfairly discriminate against any enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee.

2. However, nothing shall prohibit a health maintenance organization from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

3. No health maintenance organization shall expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of the health status or health care needs of the individual enrollee or member.

Section V. Services.

A. Access to Care.

1. A health maintenance organization shall establish and maintain adequate arrangements to provide the health services contracted for by its subscribers including:

a. reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

b. reasonable hours of operation and after-hours services;

c. emergency care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week; and

d. sufficient providers and personnel, including health professionals, administrators and support staff, to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

2. A health maintenance organization utilizing primary care physicians shall make primary care physician services available to each enrollee and shall provide accessibility to medically necessary specialists through staffing, contracting or referral. Such a health maintenance organization shall provide for continuity of care for enrollees referred to specialists.

3. A health maintenance organization shall have written procedures governing the availability of frequently utilized services contracted for by enrollees, including at least the following:

a. well-patient examinations and immunizations;

b. emergency telephone consultation on a twenty-four (24) hours per day, seven (7) days per week basis;

c. treatment of emergencies;

d. treatment of minor illness; and

e. treatment of chronic illnesses.

B. Basic Health Care Services. A health maintenance organization shall provide, or arrange for the provision of, as a minimum, basic health care services which shall include the following:

1. Emergency care services, as defined in Section 1 of this regulation.

2. Inpatient hospital services, meaning medically necessary hospital services including, but not limited to, room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory and other diagnostic tests; drugs, medications, biologicals, anesthesia and oxygen services; special nursing when medically necessary; physical therapy, radiation therapy and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services.

3. Inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services.

4. Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a non-hospital-based health care facility, or at a hospital. Outpatient medical services shall include but are not limited to diagnostic services; treatment services; laboratory services; x-ray services; referral services; and physical therapy, radiation therapy and inhalation therapy. Outpatient services shall also include preventive health services which shall include, at least a broad range of voluntary family planning counseling services, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

C. Out-of-Area Services and Benefits.

1. Copayments or deductibles for out-of-area services shall be shown in the contract and evidence of coverage.

2. When an enrollee is traveling or temporarily out of a health maintenance organization's service area, a health maintenance organization shall provide benefits for reimbursement for emergency care services subject to the following condition:

a. the condition could not reasonably have been foreseen;

b. the enrollee could not reasonably arrange to return to the service area to receive treatment from the health maintenance organization's provider;

c. the travel must be for some purpose other than the receipt of medical treatments; and

d. the health maintenance organization is notified by telephone within twenty-four (24) hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the health maintenance organization in such time limits.

3. Services received by an enrollee outside of the health maintenance organization's service area will be covered only so long as it is unreasonable to return the enrollee to the service area.

D. Supplemental Health Care Services.

1. In addition to the basic health care services required to be provided in Subsection B of this Section, a health maintenance organization may offer to its enrollee any supplemental health care services it chooses to provide.

2. Limitations as to time and cost may vary from those applicable to basic health care services.

Section VI. Other Requirements.

A. Description of Providers.

1. A health maintenance organization shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the contract and evidence of coverage are issued and upon request thereafter. If a provider is no longer affiliated with a health maintenance organization, the health maintenance organization shall provide notice of such change to its affected subscribers and to the Department in a timely manner. Subject to the approval of the Commissioner, a health maintenance organization may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

2. Any list of providers shall contain a notice regarding the availability of the listed providers. Such notice shall be in not less than twelve point type and be placed in a prominent place on the list of providers. The notice shall contain the following language: Enrolling in [name of HMO] does not guarantee services by a particular provider on this list. If you wish to be sure of receiving care from specific providers listed, you should contact the health maintenance organization to be sure that the particular provider is accepting additional patients for [name of HMO]. Even if a particular provider is participating in [name of HMO] on the date you enroll, there is no guarantee that the provider will continue to participate during the entire term of your enrollment in [name of HMO].

B. Description of the Service Area.

1. A health maintenance organization shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the contract and evidence of coverage is issued and upon request thereafter.

2. If the description of the service area is changed, the health maintenance organization shall provide at such time a new description of the service area to its affected subscribers and to the Department.

C. Copayments and Deductibles.

1. A health maintenance organization may require copayments or deductibles of enrollees as a condition for the receipt of specific health care services.

2. Copayments or deductibles for basic health care services shall be shown in the contract and evidence of coverage.

D. Complaint System.

1. A complaint system shall be established and maintained by a health maintenance organization to provide reasonable procedures for the prompt and effective resolution of written complaints.

2. The complaint system shall provide for written acknowledgement of complaints and complaints to be resolved or to have a final determination of the complaint by the health maintenance organization complaint system within a reasonable period of time, but not more than ninety (90) days from the date the complaint is registered. This period may be extended in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or by the mutual written agreement of the health maintenance organization and the enrollee.

3. Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made a reasonable effort to resolve the written complaint through its complaint system and coverage is being terminated as provided for in Subsection B of Section IV.

4. If enrollee complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any health maintenance organization that makes such binding arbitration a condition of enrollment must fully disclose this requirement to its enrollees in the contract and evidence of coverage.

Section VII. Severability.

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

Section VIII. Effective Date.

A. This regulation shall become effective ninety (90) days after final publication in the State Register.

B. All health maintenance organization contracts issued or renewed after this date must comply with its provisions.

HISTORY: Amended by State Register Volume 14, effective 90 days after publication in State Register, published April 27, 1990; State Register Volume 26, Issue No. 6, Part 2, eff June 28, 2002.

Code Commissioner's Note

Pursuant to 2011 Act No. 47, § 14(B), the Code Commissioner substituted "intellectual disability" for "mental retardation" and "person with intellectual disability" or "persons with intellectual disability" for "mentally retarded".

69–23. Adjuster, Public Adjuster, Appraiser, Broker, Bondsmen, Runner, Producer and Agency Licenses.

Section I. Purpose

The purpose of this regulation is to specify requirements related to licenses issued by the Department.

Section II. Licenses required for each agency

A. Each agency, as defined in Section 38–1–20(26) of the 1976 Code, as amended, shall make application for licensure to the director or his designee on the Uniform Business Entity Application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct, and complete to the best of the applicant's knowledge and belief. This applies to each corporation, association, partnership, limited liability company, limited liability partnership, or other business entity in which more than one person has a financial interest or which operates under a corporate or trade name. The requirement for an agency license does not apply to any agency owned by, and operated under the name of, an individual licensed producer, so long as no other person, firm or entity has any interest in, or affiliation with, the business of the individual producer or his agency.

B. No such agency shall be licensed under a name which is likely to lead a person of average intelligence to believe that the agency is an insurer, an agency of any government, or a club, fraternity, association or social or military organization, or which is otherwise deceptive or misleading. Foreign corporations, limited partnerships and any other entities are required by law to be registered with the South Carolina Secretary of State's Office.

C. The agency is required to submit the application to the Department of Insurance and to pay the required fee; however, each insurer is required to notify all its agencies of their responsibility to file an agency application and to pay the required fee. Only one agency license is required for each agency regardless of the number of insurers it represents or the number of locations. At any time that an agency has no stockholder, officer, director, member, employee or associate possessing a current, active individual producer's license, the agency license shall be deemed terminated.

Section III. Citizenship requirements for Producers, Adjusters, Public Adjusters, Appraisers, Brokers, Bondsmen, and Runners

A. Producers. Only natural persons may be licensed and appointed as producers to represent an insurance company. The applicant shall be a citizen of the United States or provide documentation that the applicant is a properly registered alien residing in the United States.

B. Adjusters, Public Adjusters, Appraisers, Brokers, Bondsmen and Runners. The applicant shall be a citizen of the United States or provide documentation that the applicant is a properly registered alien residing in the United States.

Section IV. Appointments

After becoming licensed, producers must be appointed by an insurer licensed in the State for the kinds of insurance for which the applicant is licensed and seeks to transact business. Every such appointing insurer is accountable for the accuracy and veracity of the certification of the applicant's reputation and trustworthiness. Information obtained from commercial reporting sources concerning the reputation of an applicant must be retained by the appointing insurer for at least five (5) years and shall be made available to the Department of Insurance upon request made by the Department.

Section V. Successful Completion of Examination

A. Producers. An applicant for licensure as a resident producer shall stand a written examination.

B. Adjusters. So as to assure himself that applicants for an adjuster's license under Code Section 38–47–10 have sufficient knowledge of the insurance business, the Director will require those applicants to stand a written examination.

(1) An adjuster applicant holding a designation as Chartered Property and Casualty Underwriter (CPCU) or Chartered Life Underwriter (CLU) relevant to the kinds of insurance for which he seeks authority shall not be required to stand a written examination prior to being issued a license.

(2) Nonresident applicants for an adjuster's license who are licensed in their home state or any other state requiring a licensing examination shall not be required to stand a written examination prior to being issued a license.

(3) If an applicant not currently licensed was previously licensed in respect to the kinds of insurance for which he seeks a license within the immediately preceding ninety days, and such license was not suspended, canceled or revoked, the Director may waive the requirement of a written examination.

C. Public Adjusters, Appraisers, Bondsmen, Runners and Brokers shall take written examinations as provided for by statute.

D. Applicants scoring at least seventy (70) points on the examination will be issued a certificate to signify successful completion of the examination, which certificate shall be valid for twelve months only. Upon submission of such certificate to the Department of Insurance, and upon the applicant's meeting all requirements to become licensed, the appropriate license will be issued.

E. Applicants scoring less than seventy (70) points shall be deemed to have failed the examination. An applicant may take each examination six (6) times during any twelve month period, upon complying with all applicable registration, fee and test procedure requirements.

Section VI. Absence of criminal record

A. Producers. An insurance company is required to investigate the "character and record" of a person whom the company wishes to appoint as its producer, and to vouch for the trustworthiness and qualifications of such person to act as an appointed producer for the insurer. In determining whether an individual is eligible to be licensed as an insurance producer, the Director must, among other things, consider whether the individual has been convicted of, or pleaded guilty or nolo contendere to, a crime involving moral turpitude. Every applicant for a producer's license must provide a copy of his criminal history record to the Director when applying for a license. The Director must also consider whether the individual has had an insurance producer license, or its equivalent, denied, suspended, or revoked in this state or another state, province, district, or territory.

B. Adjusters, Public Adjusters, Appraisers, Bondsmen, Runners and Brokers. The Director must be satisfied that a person applying for a license is of good moral character, has not violated any of the insurance laws of this State or any other state, and is a fit and proper person for a license. So as to permit the Director to make such a determination, every applicant for a license must provide a copy of

his criminal history record to the Director when applying for a license. The Director must also consider whether the individual has had a license, or its equivalent, denied, suspended, or revoked in this state or another state, province, district, or territory.

Section VII. Special requirements for variable contracts licensing

In order to be licensed to sell either variable life insurance or variable annuities, an applicant must meet the following requirements:

(1) The applicant must furnish evidence that he has passed a securities examination administered by the National Association of Securities Dealers (NASD), the Securities and Exchange Commission (SEC) or the Securities Commissioner of South Carolina;

(2) The applicant must furnish evidence that he has passed a variable contracts examination. The variable contracts examination may be waived if the applicant furnishes evidence that he has passed the NASD Series 6 or Series 7 examination or any other examination which in the opinion of the Director sufficiently tests the applicant's knowledge of variable contracts.

HISTORY: Amended by State Register Volume 8, Issue No. 6, eff June 22, 1984; State Register Volume 12, Issue No. 7, eff July 1, 1988; State Register Volume 34, Issue No. 6, eff June 25, 2010.

69–24. Workmen's Compensation—Dividends to Policyholders.

Section 1. Background and Purpose. It has come to the attention of the South Carolina Insurance Commission that some Workmen's Compensation insurers and agents may be using unfairly discriminatory and other misleading practices in connection with policyholder dividend plans. In order to aid the South Carolina Insurance Commission in its efforts to prevent such practices and enforce the insurance laws of this state pertaining to such unlawful practices, the following regulation is deemed necessary.

Section 2. Rules for Filing of Dividend Plans. Each insurer which intends to issue Workmen's Compensation policies on a participating basis in South Carolina shall file with the Chief Insurance Commissioner of South Carolina any dividend plan or plans already implemented or intended to be implemented by such insurer including any amendments thereto. Each such insurer shall also attach to every workmen's compensation policy an endorsement thereto reading as follows:

The insured shall participate in the earnings of the company, only in accordance with law and with a plan applicable to this policy which has been filed with the Chief Insurance Commissioner of South Carolina, provided the insured has complied with all the terms of this policy with respect to the payment of premium.

Neither dividends nor any factor in their calculation may be guaranteed. By purchasing this policy, the insured obtains no contractual right to a dividend. Dividends are declared in the sole discretion of the governing body of the insurer, in accordance with law. Any representations to the contrary are false.

In lieu of an endorsement, the same or substantially similar wording may be incorporated as condition 18 of the standard Workmen's Compensation policy.

Section 3. Compliance with Insurance Laws and Regulations. Any dividend plan or plans filed pursuant to this regulation may provide for a reasonable classification of risks for purposes of determining dividends, but may not provide for rebates of premium or unfair discrimination in favor of individuals between insureds of the same class and hazard, as described in § 38-55-50. Specifically, any dividend plan which provides for higher rates of dividend and lower rates of commission, to risks with other characteristics affecting losses and expenses remaining the same, shall be deemed to be in violation of § 38-55-50. Any dividend plan which provides that dividends may not be paid under a policy unless the policy is renewed in the same company shall be deemed to be in violation of § 38-57-130.

This regulation in no way modifies or extends any of the sections dealing with unfair trade practices, §§ 38-57-20, et seq., and violations shall be treated pursuant to the procedures set forth in §§ 38-57-200 through 38-57-320 of the South Carolina Code of Laws of 1976, as amended.

Section 4. Effective Date. This regulation shall take effect 120 days after it is filed with the Secretary of State except that insurers may immediately upon the filing of the Regulation with the Secretary of State submit such dividend plans to the Chief Insurance Commissioner in accordance with this Regulation. (Based on Insurance Commission designation R11-76.)

69–25. Prohibition Against Decreases in Income Benefits From Group Disability Policies Due to Increases in Social Security Benefits.

Section 1. Purpose. The purpose of this Regulation is to prohibit insurers from including an offset of increased social security benefits in group disability income policies. While there may be justification from a rate standpoint for permitting integration of disability income benefits and social security benefits in determining the initial disability income payment to a disabled person, there is no justification for offsetting increases in social security benefits that occur after the disability commences. When Congress increases social security benefits to disabled persons it is to provide the disabled persons with additional income regardless of any other income or insurance benefits payable to such persons. Accordingly, to permit such an offset would nullify the purpose of the social security legislation and would result in an inequity which is contrary to the expectations of the disabled insured.

Section 2. Applicability. This Regulation shall apply to all group disability income policies delivered or issued for delivery in this State after the effective date hereof; and to existing group policies on the renewal anniversary date.

Section 3. Prohibition. No group disability income policy which integrates benefits with social security benefits shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes in the level of social security benefits resulting either from changes in the social security law or due to cost of living adjustments which become effective after the first day for which disability benefits become payable.

Section 4. Effective Date. This Regulation shall take effect 120 days after it has been filed with the Secretary of State.

69–27. Guaranty Act—Applicability.

Section 1. Purpose. The purpose of this regulation is to require that brokers fully and fairly disclose to all policyholders of insurers not licensed to do business in this State that the provisions of the South Carolina Insurance Guaranty Association Act, (Sections 38-31-30 et seq., Code of Laws of South Carolina, 1976, as amended) which protect policyholders in the event of a property and casualty company insolvency, do not apply to an unauthorized, unlicensed carrier.

Section 2. Requirement. Consistent with the above stated purpose, on or after the effective date of this regulation, no broker shall place or renew any insurance with any insurer not licensed in this State unless he shall write or stamp upon the face of each policy or evidence of renewal of an insurer not licensed in this State the words "The S. C. Guaranty Act does not apply to this policy."

Section 3. Alternative. Inasmuch as § 38-45-110, South Carolina Code of Laws, similarly requires that the words "This Company Not Licensed to do business in this State" to be written or stamped upon the face of each policy of an insurer not licensed in this State, the two requirements may be filled conjunctively. To Wit: In fulfilling the requirements of § 38-45-110 and this Regulation, the broker may write or stamp upon the face of each policy or evidence of renewal of an insurer not licensed in this State the words "This Company is Not Licensed to do Business in this State, and the S. C. Guaranty Act does Not Apply to This Policy." (Provisions based on Insurance Commission designation R11-76.)

Editor's Note

This regulation was adopted August 11, 1976.

69–29. Suitability in Annuity Transactions.

Section I. Purpose

A. The purpose of this regulation is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Section II. Scope

This regulation shall apply to any recommendation to purchase, exchange or replace an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

Section III. Exemptions

Unless otherwise specifically included, this regulation shall not apply to transactions involving:

A. Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation;

B. Contracts used to fund:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;

(3) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the IRC;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.

Section IV. Definitions

As used in this regulation, unless the context otherwise requires:

A. "Annuity" means each contract or agreement to make periodic payments, whether in fixed or variable dollar amounts, or both, at specified intervals that is an insurance product under State law that is individually solicited, whether the product is classified as an individual or group annuity.

B. "Continuing education credit hour or "credit hour" means one continuing education credit as defined in S.C. Code of Regulations 69–50.

C. "Continuing education approved sponsor" or "CE Approved Sponsor" means an individual or entity that is approved to offer continuing education courses pursuant to S.C. Code of Regulations 69–50.

D. "FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

E. "Insurer" means a company required to be licensed under the laws of this State to provide insurance products, including annuities and as further defined in S.C. Code Section 38–1–20(33).

F. "Insurance producer" or "producer" means a person required to be licensed pursuant to S.C. Code Section 38–43–10 et seq. to sell, solicit or negotiate insurance, including annuities.

G. "Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice.

H. "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer involved, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

I. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including the financial resources used for the funding of the annuity;

(4) Financial experience;

(5) Financial objectives;

(6) Intended use of the annuity;

(7) Financial time horizon;

(8) Existing assets, including investment and life insurance holdings;

(9) Liquidity needs;

(10) Liquid net worth;

(11) Risk tolerance; and

(12) Tax status.

Section V. Duties of Insurers and of Insurance Producers

A. In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

(1) The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. The requirements of this section supplement and do not replace the disclosure requirements of South Carolina Code of Regulations 69–39.

(2) The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

(a) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(b) The consumer would benefit from product enhancements and improvements; and

(c) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

B. Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

C. Except as permitted under subsection D of this section, an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

D.(1) Except as provided under paragraph (2) of this subsection, neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subsection A or C of this section related to any annuity transaction if:

(a) No recommendation is made;

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

(2) An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

E. An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

(1) Make a record of any recommendation subject to this regulation;

(2) Obtain a customer signed statement documenting a customer's refusal to provide suitability information, if any; and

(3) Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

F.(1) An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with this regulation, including, but not limited to, the following:

(a) The insurer shall maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant insurance producer training manuals;

(b) The insurer shall establish standards for insurance producer product training and shall maintain reasonable procedures to require its producers to comply with the requirements of this regulation;

(c) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(d) The insurer shall maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(e) The insurer shall maintain reasonable procedures to detect recommendations that are not suitable. This may include, but is not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. An insurer may comply with this subparagraph by applying sampling procedures or by confirming suitability information after issuance or delivery of the annuity; and

(f) The insurer shall annually provide a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(2)(a) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph (1). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section VII of this regulation regardless of whether the insurer contracts for perform-

ance of a function and regardless of the insurer's compliance with subparagraph (b) of this paragraph.

(b) An insurer's supervision system under paragraph (1) shall include supervision of contractual performance under this paragraph. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(3) An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer.

G. An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer's request for confirmation of suitability information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

H.(1) Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the director's ability to enforce (including investigate) the provisions of this regulation.

(2) For paragraph (1) to apply, an insurer shall:

(a) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

(b) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Section VI. Insurance Producer Training

A. An insurance producer shall not sell, solicit, or negotiate an annuity product unless the producer:

(1) is authorized as an insurance producer for life insurance products;

(2) has adequate knowledge of the product to recommend the annuity;

(3) has completed a one-time training course as set forth in subsection B of this section; and

(4) is in compliance with the insurer's standards for product training.

A producer may rely on insurer-provided product-specific training standards and materials to comply with the insurer's standards for product training.

B.(1)(a) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) hour training course.

(b) Insurance producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credit hours, but may be longer.

(3) The training required under this subsection shall include at a minimum information on the following topics:

(a) The types of annuities and various classifications of annuities;

(b) Identification of the parties to an annuity;

(c) How fixed, variable and indexed annuity contract provisions affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Regulatory requirements relating to sales practices, replacement and disclosure requirements.

Additional topics may be offered in conjunction with and in addition to the required outline.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE Approved Sponsor in this State and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in S.C. Code of Regulations 69–50

(6) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with S.C. Code Section 38–43–106 and S.C. Code of Regulations 69–50.

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with S.C. Code of Regulations 69–50.

(8) The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(9) An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by NAIC-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with CE Approved Sponsors.

Section VII. Compliance, Penalties

A. An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the director may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of this regulation;

(2) A general agency, independent agency or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the violation of this regulation; and

(3) Appropriate penalties and sanctions pursuant to S.C. Code Section 38–2–10.

B. Any applicable penalty under S.C. Code Section 38–2–10 for a violation of this regulation may be reduced or eliminated if the director determines that corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Section VIII. Recordkeeping

A. Insurers, general agents, independent agencies and insurance producers shall maintain or be able to make available to the records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for five (5) years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Section IX. Effective Date

This regulation shall become effective six (6) months following final publication in the *State Register* and shall apply to contracts sold on or after the effective date of this regulation.

HISTORY: Added by State Register Volume 35, Issue No. 3, eff March 25, 2011.

69–30. Life Insurance Disclosure Regulation.

This regulation requires that all persons selling or soliciting the sale of life insurance furnish to prospective purchasers certain basic information to enable these purchasers to accurately determine their insurance needs and to make comparisons of available policies.

A. Authority. This regulation is adopted and promulgated by the Director of the South Carolina Department of Insurance pursuant to Sections 38–3–60, 38–63–10, 38–65–10, 38–69–10, and Chapter 57 of the 1976 Code of Laws of South Carolina, as amended.

B. Purpose.

(1) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs and improve the buyer's understanding of the basic features of the policy that has been purchased or is under consideration.

(2) This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other South Carolina statute or regulation.

C. Scope.

(1) Except for the exemptions specified in Section C(2), this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section E(2) shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

(2) This regulation shall not apply to:

(a) Individual and group annuity contracts;

(b) Credit life insurance;

(c) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);

(d) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. Section 1001 et seq. as amended; or

(e) Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

D. Definitions. For the purposes of this regulation, the following definitions shall apply:

(1) "Buyer's Guide" means the current Life Insurance Buyer's Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the Director of the Department of Insurance.

(2) "Current scale of nonguaranteed elements" means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

(3) "Generic Name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

(4) "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(5) "Policy data" means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

(6) "Policy Summary" means a written statement describing the elements of the policy including but not limited to:

(a) A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION;

(b) The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary;

(c) The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

(d) The Generic Name of the basic policy and each rider;

(e) The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including at least one age from sixty (60) through sixty-five (65) and policy maturity:

1. The annual premium for the basic policy;

2. The annual premium for each optional rider;

3. The amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

4. The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider; and

5. Any endowment amounts payable under the policy which are not included under guaranteed cash surrender values above;

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Policy Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law; and

(g) The date on which the Policy Summary is prepared.

(7) "Preneed funeral contract" means a contract, which has for its purpose the furnishing or performance of funeral services, or the furnishing or delivery of personal property, merchandise, services of any nature in connection with the final disposition of a dead human body, to be furnished or delivered at a time determinable by the death of the person whose body is to be disposed of, but does not mean the furnishing of a cemetery lot, crypt, niche, mausoleum, grave marker or monument.

E. Duties of Insurers.

(1) Requirements Applicable Generally

(a) The insurer shall provide a Buyer's Guide prior to accepting the applicant's initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days the Buyer's Guide may be delivered with the policy or prior to the delivery of the policy.

(b) The insurer shall provide a Policy Summary to prospective purchasers where the insurer has identified the policy form as one that will not be marketed with an illustration. The Policy Summary shall show guarantees only. It shall consist of a separate document with all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts of the policy that remain level for two (2) or more years may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Section D(6)(e) shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. Delivery of the Policy Summary shall be consistent with the time for delivery of the Buyer's Guide as specified in Paragraph (a).

(c) Upon request, the insurer shall provide to any prospective purchaser a Buyer's Guide within a reasonable time, but no more than thirty (30) days from the request.

(2) Requirements Applicable to Existing Policies

(a) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

1. For policies issued prior to January 1, 2010, the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of Regulation 69–40 then in effect.

2. For policies issued after January 1, 2010, that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of Regulation 69–40.

3. If the policy was issued after January 1, 2010 and declared to be used with an illustration, an in force illustration shall be provided.

4. Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee that must be disclosed to the policyowner at the time the request is made.

(b) If a life insurance company changes its method of determining scales of non-guaranteed elements on existing policies, it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(c) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor, it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

F. Preneed Funeral Contracts or Prearrangements.

(1) The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant's initial premium or deposit for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

(a) The fact that a life insurance policy is involved or being used to fund a prearrangement;

(b) The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

(c) The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

(d) The impact on the prearrangement:

1. Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

2. Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

3. Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

(e) A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

(f) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; and

(g) Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee.

G. General Rules.

(1) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

(2) An insurance producer shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which a producer is not involved, the insurer shall identify its full name.

(3) Terms such as financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless such is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

(4) Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company's current scale of nonguaranteed elements (use appropriate special term such as "current dividend" or "current rate" scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after January 1, 2010 that includes nonguaranteed elements over a period of years shall be governed by Regulation 69–40.

H. Failure to Comply.

Failure of an insurer to provide or deliver a Buyer's Guide, an in-force illustration, a Policy Summary or policy data as provided in Section E. shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy in violation of South Carolina Code Ann. § 38–57–10 et seq.

I. Effective Date.

This rule shall become effective January 1, 2010.

HISTORY: Added by State Register Volume 2, effective June 25, 1978. Amended by State Register Volume 15, Issue No. 3, eff March 22, 1991; State Register Volume 34, Issue No. 3, eff March 26, 2010.

69–31. Practice and Procedure for Hearings Before the Chief Insurance Commissioner under the State Administrative Procedures Act, Act No. 176 of 1977.

A. Scope of rules: The rules of procedure in this regulation govern the practice for hearings, decisions, and administrative review conducted by the Chief Insurance Commissioner of South Carolina pursuant to statutory authority.

B. Records to be public: All pleadings, correspondence, exhibits, transcripts of testimony, exceptions, briefs, decisions, and other documents filed in the docket in any proceeding may be inspected and copied in the office of the Department Hearing Clerk. Inquiries may be made at or to the office of the Department Hearing Clerk, South Carolina Department of Insurance, 2711 Middleburg Drive, P. O. Box 4067, Columbia, South Carolina, 29240.

C. Use of gender and number: As used in this regulation, words importing the singular number may extend and be applied to several persons or things, and vice versa. Words importing the masculine gender may be applied to females or organizations.

D. Suspension of rules: Upon notice to all parties, the presiding officer or the Chief Insurance Commissioner, with respect to matters pending before them, may modify or waive any rule in this regulation upon determination that no party will be unduly prejudiced and that the ends of justice will thereby be served.

E. Appearance: A party may appear in person or by counsel. Counsel for a party must be members in good standing of the South Carolina Bar or associated with a member in good standing of the South Carolina Bar.

F. Authority for representation: Any individual acting in a representative capacity in any proceeding may be required to show his authority to act in such capacity.

G. Exclusion from hearing for misconduct: Disrespectful, disorderly, or contumacious language or contemptuous conduct, refusal to comply with directions, or use of dilatory tactics by any person at any hearing shall constitute grounds for immediate exclusion of such person from the hearing by the presiding officer or by the Chief Insurance Commissioner.

H. Parties; South Carolina Department of Insurance deemed a party:

(1) The term "party" means each person or agency named in a notice of opportunity for hearing and petition or admitted as a party, or properly seeking and entitled as a matter of right to be admitted as a party.

(2) The term "person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(3) The South Carolina Department of Insurance shall be deemed a party to all proceedings.

I. Amici curiae:

(1) Any interested person or organization may file a petition to participate in a proceeding as an amicus curiae. Such petition shall be filed prior to the prehearing conference, or, if none is held, before the commencement of the hearing, unless the petitioner shows good cause for filing the petition later. The presiding officer may grant the petition if he finds that the petitioner has a legitimate interest in the proceedings, that such participation will not unduly delay the outcome, and may contribute materially to the proper disposition thereof. An amicus curiae is not a party and may not introduce evidence at a hearing; nor may an amicus curiae examine or cross-examine a witness.

(2) An amicus curiae may submit a statement of position to the presiding officer prior to the commencement of the hearing, and shall serve a copy on each party. The amicus curiae may submit a brief on each occasion a decision is to be made or a prior decision is subject to review. An amicus curiae brief shall be filed and served on each party within the time limits applicable to the party whose position the amicus curiae supports; or if he does not deem himself to support the position of any party, within the longest time limit applicable to any party at that particular stage of the proceedings.

(3) After all parties have completed their initial examination of a witness, any amicus curiae may request the presiding officer to propound specific questions to the witness. The presiding officer, may, in his discretion, grant any such request if he believes that the proposed additional testimony may assist materially in explaining factual matters at issue between the parties and will not expand the issues.

J. Complainants not parties: A person submitting a complaint to the Department, regarding any matter within the jurisdiction of the Department, is not a party to a proceeding governed by this regulation, but may petition, after proceedings are initiated, to become a amicus curiae.

K. Form of documents to be filed: Documents to be filed under this rule shall be dated, the original signed in ink, shall show the docket description and title of the proceeding, and show the title, if any, and address of the person signing the document. Copies need not be signed but the name of the person signing the original shall be reproduced on all copies. Documents shall be legible and shall be eight and one-half inches wide and eleven inches long.

L. Signature of documents: The signature of a party, authorized officer, employee or attorney constitutes a certificate that he has read the document, that to the best of his knowledge, information, and belief there is good ground to support it, and that it is not interposed for delay. If a document is not signed or is signed with intent to defeat the purpose of this section, it may be stricken as sham and

false and the proceeding may proceed as though the document had not been filed. Similar action may be taken if scandalous or indecent matter is inserted in a document.

M. Filing and service: All written notices by a Department official, and all written motions, requests, petitions, memoranda, pleadings, exceptions, briefs, decisions, and correspondence to a Department official from a party, or vice versa, relating to a proceeding after its commencement shall be filed and served on all parties. Parties shall submit the original and one copy of documents for filing. Filings shall be made with the Department Hearing Clerk at the address stated in the notice of hearing or notice of opportunity for hearing, during regular business hours. Regular business hours are every Monday through Friday (legal holidays in the State of South Carolina excepted) from 8:30 a.m. to 5:00 p.m., eastern standard or daylight-saving time, whichever is effective in the State of South Carolina at the time. Originals only of exhibits and transcripts or testimony need be filed. Requirements for service on amicus curiae are set forth in BBB below.

N. Service—how made: Service shall be made by personal delivery of one copy to each person to be served or by depositing the document or documents in the United States mail, postage prepaid, addressed to the last known place of business or residence of such person, certified with return receipt requested. If a party or amicus curiae has appeared by attorney, service upon such attorney shall be deemed service upon the party or amicus. Documents served by mail should be mailed in sufficient time to reach the addressee by the date on which the original is due to be filed.

O. Date of Service: The date of service shall be the day on which the matter is deposited in the United States mail or is delivered in person, except that the date of service of the initial notice of hearing or opportunity for hearing shall be the date of its delivery, or of its attempted delivery, if delivery is refused.

P. Certificate of service: The original of every document filed and required to be served upon parties to a proceeding shall be endorsed with a certificate of service signed by the party making service or by his attorney or representative, stating that such service has been made, the date of service, and the manner of service, whether by mail or personal delivery.

Q. Computation: In computing any period of time under this rule or in an order issued hereunder, the time begins with the day following the act, event, or default, and includes the last day of the period, unless the last day is a Saturday, Sunday, or legal holiday observed in the State of South Carolina, in which event it includes the next following business day. If the period of time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays shall be excluded from the computation of time.

R. Extension of time or postponement: Requests for extension of time must be served on all parties and must set forth the reasons for the application. Applications may be granted upon a showing of good cause by the applicant. After designation of a presiding officer and until issuance of his decision, such requests must be addressed to the presiding officer. Answers or responses to such requests are permitted, if made promptly.

S. Reduction of time to file documents: Upon good cause shown, the presiding officer or the Chief Insurance Commissioner may reduce any time limit prescribed by this regulation, except as provided by law.

T. Notice of hearing or opportunity for hearing: Proceedings are commenced by service of a notice of opportunity for hearing and petition upon a party, pursuant to N above of this regulation.

U. Answer to notice: A respondent or respondents shall file an answer to the petition within ten days after service thereof. Answers shall admit or deny specifically and in detail each allegation of the petition, unless the respondent party is without knowledge, in which case his answer should so state, and the statement will be deemed a denial. Allegations of fact in the petition not denied or controverted by answer shall be deemed admitted. Matters alleged as affirmative defenses shall be separately stated and numbered. Failure of a respondent to file an answer within the ten-day period following service of the petition may be deemed an admission of all matters of fact recited in the petition.

V. Amendment of notice or answer: The General Counsel may amend the petition once as a matter of course before an answer thereto is served, and each respondent may amend his answer once as a matter of course not later than ten days before the date fixed for hearing but in no event later than ten days from the date of service or his original answer. Otherwise, a petition or answer may be

amended only by leave of the presiding officer. A respondent shall file his answer to an amended petition within the time remaining for filing the answer to the original petition or within ten days after service of the amended petition, whichever period may be the longer, unless the presiding officer otherwise orders.

W. Request for hearing: If neither a petition nor notice of opportunity for a hearing fix a date for hearing, a respondent, either in his answer or in a separate document, may request a hearing. Failure of a respondent to request a hearing shall be deemed a waiver of the right to a hearing and to constitute his consent to the making of a decision on the basis of such information as is available to the Department.

X. Consolidation: The Chief Insurance Commissioner may provide for proceedings in the Department to be joined or consolidated for hearing with proceedings in other State departments or agencies, by agreement with such other departments or agencies. All parties to any proceeding consolidated subsequent to service of a notice of opportunity for hearing and petition shall be promptly served with notice of such consolidation.

Y. Motions and petitions: Motions and petitions shall state the relief sought, the authority relied upon, and the facts alleged. If made before or after a hearing, these matters shall be in writing. If made at a hearing, they may be stated orally; provided, however, the presiding officer may require that they be reduced to writing and filed and served on all parties in the same manner as a formal motion. Motions, petitions, answers and replies shall be addressed to the presiding officer, if the case is pending before him. A repetitious motion or petition will not be entertained.

Z. Responses to motions and petitions: Within five days after a written motion or petition is served, or such other period as the Chief Insurance Commissioner or the presiding officer may fix, any party may file a response thereto. An immediate oral response may be made to an oral motion.

AA. Disposition of motions and petitions: The presiding officer or the Chief Insurance Commissioner may not sustain or grant a written motion or petition prior to expiration of the time for filing responses thereto, but may overrule or deny such motion or petition without awaiting response: Provided, however, that pre-hearing conferences, hearings and decisions need not be delayed pending disposition of motions or petitions. Oral motions and petitions may be ruled on immediately. Motions and petitions submitted to the presiding officer or the Chief Insurance Commissioner which are not disposed of in separate rulings or in their respective decisions or report will be deemed denied. Oral arguments shall not be held on written motions or petitions unless the presiding officer or the Chief Insurance Commissioner in his discretion, expressly so orders.

BB. Who Presides: The Chief Insurance Commissioner or a presiding officer designated and assigned by the Chief Insurance Commissioner shall preside over the taking of evidence in any hearing to which these rules of procedure apply.

CC. Designation of presiding officer: Designation by the Chief Insurance Commissioner of a presiding officer shall be in writing, and shall be signed by the Chief Insurance Commissioner or by his designee. The document signed by the Chief Insurance Commissioner or his designee, designating a presiding officer, shall specify whether the presiding officer is to hold a hearing and make a report or to certify the entire record, including his findings of fact, conclusions, recommendations and proposal for decision to the Chief Insurance Commissioner as required by these regulations, and may also fix the time and place of hearing. A copy of such order, designating an individual as a presiding officer, shall be served on all parties. After service of an order designating a presiding officer, and until such officer makes his report, all motions and petitions shall be submitted to him. In the case of the death, illness, disqualification or unavailability of the designated presiding officer, another presiding officer may be designated by the Chief Insurance Commissioner, or by his designee, to take his place.

DD. Authority of presiding officer: The presiding officer shall have the duty to conduct a fair hearing, to take all necessary action to avoid delay, and to maintain order. He shall also have all powers necessary to these ends, including, but not limited to, the authority to:

(1) Arrange and issue notice of the date, time, and place of hearings, or, upon due notice to the parties, to change the date, time, and place of hearings previously set;

(2) Hold conferences to settle, simplify, or fix the issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(3) Require parties and amici curiae to state their position with respect to the various issues in the proceeding;

(4) Administer oaths and affirmations;

(5) Rule on motions, and other procedural matters pending before him;

(6) Regulate the course of the hearing and conduct of counsel at the hearing;

(7) Examine witnesses and direct witnesses to testify;

(8) Receive, rule on, exclude or limit evidence and testimony;

(9) Fix the time for filing motions, petitions, briefs, or other matters pending before him;

(10) Issue findings of fact and of law, conclusions, recommendations and proposed decisions; and

(11) Take any action authorized by this rule of procedure or in conformity with the provisions of Article II of Act 176 of 1977 (Administrative Procedures) and the insurance laws of South Carolina.

EE. Statement of position and briefs: The presiding officer may require parties and amici curiae to file written statements of position prior to the beginning of a hearing. The presiding officer may also require the parties to submit briefs.

FF. Evidentiary purpose:

(1) Hearings shall be held for the purpose of receiving factual evidence and expert opinion testimony related to the issues in the proceeding. Arguments will not be received in evidence; rather they should be presented in statements, memoranda, or briefs, as determined by the presiding officer. Brief opening statements, as to a party's position and what he intends to prove, may be made at hearings.

(2) Hearings for the reception of evidence will be held only in cases where issues of fact must be resolved or when required by law. In any case where it appears from a respondent's answer to the petition, from his failure to timely answer, or from his admissions or stipulations in the record, that there are no matters of material fact in dispute, the presiding officer may enter an order so finding, vacating the hearing date if one has been set, and fixing the time for filing briefs under WW below. Thereafter, the proceedings shall continue to a conclusion in accordance with WW through BBB below. The presiding officer may allow an interlocutory appeal to the Insurance Commissioner from such an order in accordance with TT below.

GG. Testimony: Testimony shall be given orally under oath or affirmation by witnesses at the hearing; but the presiding officer may, in his discretion, require or permit direct testimony of any witness to be prepared in writing and served on all parties in advance of the hearing. Such testimony may be adopted by the witness at the hearing, and filed as part of the record thereof. Unless authorized by the presiding officer, witnesses will not be permitted to read prepared testimony into the record. Except as provided in II and JJ below, witnesses shall be available at the hearing for cross-examination.

HH. Exhibits: Proposed exhibits shall be exchanged and marked for identification at a pre-hearing conference, or otherwise prior to the hearing if the presiding officer so requires. Proposed exhibits not so exchanged and marked may be denied admission as evidence. The authenticity of all proposed exhibits exchanged prior to a hearing will be deemed admitted unless written objection thereto is filed prior to the hearing or unless good cause is shown at the hearing for failure to file such written objection.

II. Affidavits: An affidavit is admissible in evidence subject to the following qualifications. Unless the presiding officer fixes other time periods, affidavits shall be filed and served on the parties not later than ten days prior to the hearing; and not less than five days prior to hearing a party may file and serve written objection to any affidavit on the ground that he believes it necessary to test the truth of assertions therein at the hearing. In such event, the assertions objected to will not be received in evidence unless the affiant is made available for cross-examination at the hearing, or the presiding officer determines that cross-examination is not necessary for the full and true disclosure of facts referred to in such assertions. Notwithstanding any objection, however, affidavits may be considered in the case of any respondent who waives a hearing.

JJ. Depositions: Upon such terms as may be just, for the convenience of the parties or of the Department, the presiding officer may authorize or direct the testimony of any witness to be taken by deposition.

KK. Admissions as to facts and documents: Not later than fifteen days prior to the scheduled date of the hearing except for good cause shown, or prior to such earlier date as the presiding officer may order, any party may serve upon an opposing party a written request for the admission of the genuineness and authenticity of any relevant documents described in and exhibited with the request, or for the admission of the truth of any relevant matters of fact stated in the request. Each of the matters of which an admission is requested shall be deemed admitted, unless within a period designated in the request (not less than ten days after service thereof, or within such further time as the presiding officer or the Chief Insurance Commissioner if no presiding officer has yet been designated may allow upon motion and notice) the party to whom the request is directed serves upon the requesting party a sworn statement either denying specifically the matters of which an admission is requested or setting forth in detail the reasons why he cannot truthfully either admit or deny such matters. Copies of any request for admission and answers thereto shall be served on all parties. Any admission made by a party to such request is only for the purposes of the pending proceeding, or any proceeding or action instituted for the enforcement of any order entered therein, and shall not constitute an admission by him for any other purpose or be used against him in any other proceeding or action.

LL. Evidence: Irrelevant, immaterial, unreliable, and unduly repetitious evidence will be excluded.

MM. Cross-examination: A witness may be cross-examined on any matter material to the proceeding without regard to the scope of his direct examination. Objections to testimony of a witness on direct examination need not be reserved and failure to reserve an objection, on cross-examination of a witness, shall not be deemed to be a waiver of any objection made during the witness's direct examination.

NN. Unsponsored written material: Letters expressing views or urging action and other unsponsored written material regarding matters in issue in a hearing will be placed in the correspondence section of the docket of the proceeding, but shall not be deemed to be part of the evidence or record in the hearing.

OO. Objections: Objections to evidence shall be timely and briefly state the ground relied upon.

PP. Exceptions to rulings of presiding officer unnecessary: Exceptions to rulings of the presiding officer are unnecessary. It is sufficient that a party, at the time the ruling of the presiding officer is sought, makes known the action which he desires the presiding officer to take, or his objection to an action taken and his grounds therefor.

QQ. Official notice: If official notice is taken or is to be taken of a material fact not appearing in the evidence of record, any party, on timely request, shall be afforded an opportunity to show the contrary.

RR. Public document items: If there is offered, in whole or in part, a public document, such as an official report, decision, opinion, or published scientific or economic statistical data issued by the executive department of the State of South Carolina or its subdivisions, legislative agencies or committees, administrative agencies of the Federal Government (including Government-owned corporations), or a similar document issued by the State of South Carolina or its agencies, and such document, or part thereof, has been shown by the offeror to be reasonably available to the public, such document need not be produced or marked for identification, but may be offered for official notice, as a public document item by specifying the document and relevant part thereof.

SS. Offer of proof: An offer of proof made in connection with an objection taken to any ruling of the presiding officer rejecting or excluding proffered oral testimony shall consist of a statement of the substance of the evidence which counsel contends would be presented by such testimony; and, if the excluded evidence consists of evidence in documentary or written form or of reference to documents or records, a copy of such evidence shall be marked for identification and shall accompany the record as the offer of proof.

TT. Interlocutory Appeals: Rulings of the presiding officer may not be appealed to the Chief Insurance Commissioner prior to the consideration of the entire proceeding except with the consent of the presiding officer and where he certifies on the record or in writing that the allowance of an

interlocutory appeal is clearly necessary to prevent exceptional delay, expense, or prejudice to any party, or substantial detriment to the public interest. If such an appeal is allowed, any party may file a brief with the Chief Insurance Commissioner within such period as the presiding officer directs. No oral argument will be heard unless the Chief Insurance Commissioner directs otherwise.

UU. Official transcript: The Department will designate the official reporter for all hearings. The official transcripts of testimony taken, together with any exhibits, briefs, or memoranda of law filed therewith shall be filed with the Department Hearing Clerk. Transcripts of testimony in hearings may be obtained from the official reporter by the parties at rates not to exceed the maximum rates fixed by rules of the Supreme Court of the State of South Carolina for transcripts furnished by official court reporters in the courts of this State. Upon notice to all parties, the presiding officer may authorize and direct corrections to the transcript which involve matters of substance.

VV. Record for decision:

(1) The record, in a contested case, shall include:

(a) All pleadings, motions, intermediate rulings and depositions;

(b) Evidence received or considered;

(c) A statement of matters officially noted;

(d) Questions and offers of proof, objections and rulings thereon;

(e) Proposed findings and exceptions;

(f) Any decision, opinion or report by the officer presiding at the hearing; and

(g) The transcript, if any, of any oral proceedings, or any part thereof, transcribed upon request of any party or by direction of the presiding officer or the Chief Insurance Commissioner.

WW. Posthearing briefs; proposed findings and conclusions:

(1) The presiding officer shall fix the time for filing posthearing briefs, which may contain proposed findings of fact, conclusions of law, recommendations, and, if permitted, reply briefs.

(2) Briefs should include a summary of the evidence relied upon together with reference to exhibit numbers and pages of the transcript, if any, with citations of the authorities relied upon.

(3) Oral proceedings, or any part thereof, shall be transcribed on request of any party or by direction of the presiding officer or the Chief Insurance Commissioner.

XX. Decisions following hearing: Upon expiration of the time allowed for submission of posthearing briefs, the presiding officer shall make a report and certify the entire record, including his findings of fact, conclusions of law, recommendations and proposal for decision to the Chief Insurance Commissioner. Findings of fact shall be based exclusively on the evidence and on matters officially noticed. A copy of the presiding officer's report, findings, conclusions, recommendations and proposal for decision shall be served upon all parties, and amici, if any.

YY. Exceptions and briefs to presiding officer's report: Within ten days after the mailing of the presiding officer's report, any party may file exceptions to the report, findings of fact, conclusions of law and recommendations and proposal for decision, with the Chief Insurance Commissioner. Briefs of the parties, and amici, if any, shall be filed within thirty days after mailing of exceptions.

ZZ. Review by Chief Insurance Commissioner: Upon the filing of such exceptions, the Chief Insurance Commissioner shall review the record and report of the presiding officer and shall issue a written order. The order or decision of the Chief Insurance Commissioner shall become a "final decision" within the meaning of Section 8, Article II of Act 176 of 1977 upon the mailing of such order or decision. All final decisions shall be served on all parties, and amici, if any.

AAA. Oral argument to the Chief Insurance Commissioner:

(1) If any party desires to argue a case orally, he shall make such request in writing. The Insurance Commissioner may grant or deny such requests in his discretion. If granted, notice of oral argument shall be served on all parties. The notice will set forth the order of presentation, the amount of time allotted, and the time and place for argument. The names of persons who will argue must be filed with the Department Hearing Clerk not later than five days before the date set for oral arguments.

(2) The purpose of oral arguments is to emphasize and clarify the written argument in the briefs. Reading at length from a brief or other texts is not favored. Participants should confine their arguments to points of controlling importance and to points upon which exceptions have been filed. Consolidations of appearances at oral arguments by parties taking the same side will permit the parties' interests to be presented more effectively in the time allotted.

(3) Pamphlets, charts, and other written material may be presented at oral arguments only if such material is limited to facts already in the record and is served on all parties and filed with the Department Hearing Clerk at least five days before the argument.

BBB. Service on amici curiae: All briefs, exceptions, memoranda, requests, orders, and decisions required to be served upon the parties shall be served upon amici curiae at the same times and in the manner required for service on parties. Any written statement of position and trial briefs required of parties under EE above shall be served on amici.

CCC. Conduct: Parties and their representatives are expected to conduct themselves with honor and dignity and observe judicial standards of practice and ethics in all proceedings. They should not indulge in offensive personalities, unseemly wrangling, or intemperate accusations or characterizations. A representative of any party shall observe the traditional responsibilities of lawyers as officers of the court and use his best efforts to restrain his client from improprieties in connection with a proceeding.

DDD. Improper conduct: It is improper for any interested person to attempt to sway the judgment of the Insurance Commissioner with respect to any proceeding by undertaking to bring pressure or influence to bear upon any officer having a responsibility for a decision in the proceeding, or his decisional staff. It is improper for any interested person or persons or any members of the Department's staff or the presiding officer to give statements to communications media, by paid advertisement or otherwise, designed or intended to influence the judgment of any officer having a responsibility for a decision in the proceeding, or his decisional staff. It is improper for any person to solicit communications from or to any such officer, or his decisional staff, other than proper communications by parties or amici curiae.

EEE. Ex parte communications: Article II, § 6 of Act 176 of 1977 governs ex parte communications in contested cases. A request for expeditious treatment of a matter pending before the presiding officer or the Chief Insurance Commissioner is deemed a communication on the merits, and is proper only after notice thereof is given to all parties. A request for information which merely inquires about the status of a proceeding without reference to the factual or legal issues is not deemed an ex parte communication, although such requests should be directed to the Department Hearing Clerk. Communications with respect to minor procedural matters or inquiries or emergency requests for extensions of time are not deemed ex parte communications.

FFF. Definitions:

(1) "Department" means the South Carolina Department of Insurance.

(2) "Notice" means notice of an opportunity for hearing.

(3) "Party" means a respondent and the South Carolina Department of Insurance.

(4) "Respondent" means the person or agency named in and upon whom a notice of opportunity for hearing and petition are served.

(5) "Commissioner" or "Chief Insurance Commissioner" means the Chief Insurance Commissioner of the State of South Carolina.

Editor's Note

This regulation was adopted June 29, 1979.

69–32. Unfair Discrimination on the Basis of Blindness or Partial Blindness.

This regulation prohibits unfair discrimination against the blind or partially blind in regard to rates or coverage by insurers.

A. The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class:

(1) Refusing to insure,

(2) or refusing to continue to insure,

(3) or limiting the amount, extent or kind of coverage available to an individual.

(4) or charging an individual a different rate from the same coverage solely because of blindness or partial blindness.

HISTORY: Amended by State Register Volume 10, Issue No. 3, eff March 28, 1986.

Editor's Note

This regulation was adopted June 22, 1979.

State Register Volume 10, Issue 3, effective March 28, 1986, on pages 193 and 1984, provide as follows:

"In connection with its amendment to the model regulation, the NAIC prepared certain drafting notes to clarify the intent of the amendments. Such drafting notes read as follows:

" 'Drafting Notes:

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

"Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his/her eyesight.

"However, an insurer may exclude from coverage disabilities, consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.'

"Several of the commentators recommended that these drafting notes be incorporated into any final regulation adopted.

"In proposing to amend Regulation 69-32, it was the intent of the Department to promulgate the amendments developed by the NAIC with all meanings attached thereto. As the drafting notes were an integral part of the NAIC's work product, the Commissioner believes that appropriate recognition should be given to those drafting notes. Consequently, while the drafting notes will not be incorporated into the main text of the regulation, the Commissioner believes that the Code Commissioner should order the drafting notes printed in the Code of State Regulations as an editor's note or reproduced in some other suitable way."

69–33. Dates for Payment of License Fees/Appointment Fees for Adjusters, Agencies, Bail Bondsmen/Runners, Brokers, Motor Vehicle Physical Damage Appraisers, Premium Service Companies, Producer Appointments, Producers, Public Adjusters, Rental Car Companies, Service Contract Providers, Third Party Administrators and Utilization Review Agents.

Section I. Purpose

The purpose of this regulation is to establish dates for the time and manner of payment of license and appointment fees.

Section II. Scope

This regulation applies to all Adjusters, Agencies, Bail Bondsmen/Runners, Brokers, Motor Vehicle Physical Damage Appraisers, Premium Service Companies, Producer Appointments, Producers, Public Adjusters, Rental Car Companies, Service Contract Providers, Third Party Administrators and Utilization Review Agents. Except for Producers, individuals and entities are not required to renew their initial license if the license was issued within one hundred eighty (180) days of the first deadline for renewal.

Section III. Dates for Payment of License and Appointment Fees

The deadline for payment of license and appointment fees is the last day of the renewal period. Unless otherwise provided by applicable law, the dates for payment of license and appointment fees will be as follows:

A. Annual License Renewals

Third Party Administrators	February 1 - March 1
Bail Bondsmen/Runners	June 1 - June 30
Service Contract Providers	September 1 - September 30

B. Biennial License Renewals

(1) Even-numbered year renewals

Agencies	January 1 - January 31
Premium Service Companies	February 1 - March 1
Brokers	May 1 - May 31
Utilization Review Agents	June 1 - June 30

	Producer Appointments	September 1 - September 30
	Public Adjusters	October 1 - October 30
	Rental Car Companies	December 1 - December 31
(2)	Odd-numbered year renewals	
	Adjusters	August 1 - August 31
	Motor Vehicle Physical Damage Appraisers	October 1 - October 31

C. Producer License Renewal

All licensed producers must renew their license and pay the license renewal fee by the last day of the individual's month of birth. An individual born in an odd-numbered year shall comply every odd-numbered year. An individual born in an even-numbered year shall comply every even-numbered year.

Section IV. Effect of Failure to Pay Fees by Deadline

If fees are not paid by the last day of the applicable renewal period designated above, the license and/or appointment(s) will lapse or cancel as specified by statute. Any other license contingent upon having a particular license will also lapse or cancel.

Section V. Reinstatement

A. Except as otherwise provided by applicable statute, any license(s) (other than producer licenses) so lapsed or canceled may be reinstated upon the individual's or entity's compliance with each of the following:

(1) compliance with the applicable licensing or other license qualification statute;

(2) payment of the applicable fees; and

(3) payment of a penalty fee in the amount of four (4) times the license renewal fee or $250, whichever is greater.

B. Producer license reinstatement. A producer may reinstate a lapsed license by:

(1) complying with all licensing requirements, including continuing insurance education, within six (6) months of the individual's compliance deadline;

(2) payment of the applicable fees; and

(3) payment of a reinstatement fee of up to $250.

C. Reinstatement of Appointments. An insurer may reinstate appointments that have been canceled subject to each of the following:

(1) the producer(s) complying with all licensing requirements;

(2) payment by the insurer of the regular biennial appointment fee(s); and

(3) payment of a $250 penalty fee per appointment.

Section VI. Effective Date: This regulation shall become effective upon final publication in the *State Register* and implementation will begin for each type of license on the established date following.

HISTORY: Amended by State Register Volume 15, Issue No. 5, eff May 24, 1991; State Register Volume 34, Issue No. 5, eff May 28, 2010.

Editor's Note

This regulation was adopted June 8, 1979.

69–34. Individual Accident and Health Insurance Minimum Standards.

(Statutory Authority: 1976 Code §§ 1–23–10 et seq., 38–3–110(2), 38–71–530, 38–71–540, 38–71–550)

A. Table of Contents:

B . . . . . Purpose
C . . . . . Applicability and Scope
D . . . . . Effective Date
E . . . . . Policy Definitions
F . . . . . Prohibited Policy Provisions
G . . . . . Accident and Health Minimum Standards for Benefits

H . . . . . Required Disclosure Provisions
I . . . . . Severability

B. Purpose: The purpose of this regulation is to implement Section 38-71-510, et seq., so as to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies and individual subscriber contracts of hospital, medical and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and health insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

C. Applicability and Scope: This Regulation shall apply to all individual accident and health insurance policies and individual subscriber contracts of hospital and medical and dental service corporations delivered or issued for delivery in this State, except that it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with this Regulation, nor shall it apply to Medicare Supplement policies issued in accordance with Regulation 69-46. The requirements contained in this Regulation shall be in addition to any other applicable regulations promulgated by the Commissioner.

D. Effective Date: This Regulation shall become effective July 13, 1981.

E. Policy Definitions: Except as provided hereafter, no individual accident or health insurance policy or hospital, medical, or dental service corporation subscriber contract delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

(1) "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and re-admission for the same or related causes to the hospital occurs within a period of time not more than the greater of 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(2) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(a) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

1. be an institution operated pursuant to law; and

2. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

3. provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "hospital" may state that such term shall not be inclusive of:

1. convalescent homes, convalescent, rest, or nursing facilities; or

2. facilities primarily affording custodial, educational or rehabilitory care; or

3. facilities for the aged, drug addicts or alcoholics; or

4. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered where a legal liability exists for charges made to the individual for such services.

(3) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities, and available services.

(a) A definition of such home or facility shall not be more restrictive than one requiring that it:

1. be operated pursuant to law;

2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

5. maintain a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

1. any home, facility or part thereof used primarily for rest;

2. a home or facility for the aged or for the care of drug addicts or alcoholics; or

3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

(4) "Accident," "Accidental Injury," "Accidental Means;" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause and which occurs while the insurance is in force.

Such definition may provide that injuries shall not include injuries for which benefits are provided under workmen's compensation, employer's liability or similar laws, motor vehicle no-fault plans, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(5) Except as provided in F(1), "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workman's compensation, occupational disease, employer's liability or similar law.

(6) "Pre-existing condition" shall not be defined to be more restrictive than (a) or (b) as stated below. (a) shall apply where the insurer uses an application form designed to elicit the complete health history of a prospective insured and, on the basis of the answers on that application, underwrites in accordance with the insurer's established standards. (b) shall apply where the insurer elects to use a simplified application, with or without a question as to the applicant's health at the time of application, or elects not to use any application.

(a) A condition misrepresented or not revealed in the application and for which symptoms existed prior to the effective date of coverage that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by or received from a physician.

(b) A condition for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one (1) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person.

(7) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." However, the use of such terms may not exclude payment or reimbursement otherwise provided by the policy which is performed by a duly licensed podiatrist, chiropractor or oral surgeon when he is acting within his legal scope of practice.

(8) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed

vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(9) Total Disability:

(a) "Total Disability" shall not be defined more restrictively than the inability of the insured to engage in his own occupation during the first year of disability or for the length of the benefit period if less than one year. After the first year of disability, total disability may be defined as the complete inability of the insured to engage in any employment or occupation for which the insured is qualified by reason of education, training or experience. The definition of such word may allow the insurer to require reasonable conditions that the insured not be in fact engaged in any occupation for wage or profit.

(b) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or (b) Engage in any training or rehabilitation program.

(c) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

(10) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(11) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the Commissioner adequately and fairly describes the benefit.

(12) "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 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.

(13) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

F. Prohibited Policy Provisions and Practices.

(1) No policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix, tonsils, hemorrhoids and piles. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis and if there is no previous medical history of the condition which predates the policy. Accident policies shall not contain probationary or waiting periods.

(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment or reduction in premium is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. This provision shall not be so construed as to prevent an insurer from voluntarily endorsing a policy so as to increase all future benefits without an increase in premium.

The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(3) A policy which is non-cancellable or guaranteed renewable may contain a "return of premium" or "cash value" benefit so long as: (1) such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and (2) the insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

(4) Notwithstanding the permissible definition of hospital in Section E(2)(b)4., a hospital confinement indemnity policy shall not exclude coverage merely because of confinement in any government related hospital.

(5) A policy issued to a person eligible for Medicare by reason of age may not have limitations or exclusions more restrictive than those of Medicare for any type of coverage under such policies.

(6) No policy shall limit or exclude coverage by type of illness, accident, treatment, or medical condition more stringent than the following:

(a) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(b) mental or emotional disorders, alcoholism and drug addiction;

(c) normal pregnancy and childbirth except for Disability Income policies defined in section G(6) of this regulation;

(d) illness, accident, treatment or medical condition arising out of:

1. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto,

2. suicide, sane or insane, attempted suicide or intentionally self-inflicted injury,

3. aviation,

4. with respect to short-term nonrenewable policies, interscholastic sports;

(e) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(f) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(g) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

(h) treatment provided in a government hospital (except a hospital confinement policy); benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employers liability or occupational disease law, any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed 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) dental care or treatment

(j) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(k) rest cures, custodial care, transportation and routine physical examinations;

(*l*) territorial limitations.

(7) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of insurance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

(8) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the Commissioner to disapprove other policy provisions in accordance with Section 38-71-530(b) which, in the opinion of the Commissioner, are unjust, unfair, misleading, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

(9) No policy shall include a provision which gives the insurer an unconditional right of non-renewal.

(10) No policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy.

G. Accident and Health Minimum Standards for Benefits.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and health insurance or non-profit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts serve a valid economic and social purpose and are approvable as Limited Benefit Health Insurance and the Outline of Coverage complies with the appropriate outline in section H(11) of this Regulation. Each such policy shall contain the words "LIMITED BENEFITS" or "LIMITED OR SUPPLEMENTAL BENEFITS" prominently displayed on the first page of the policy in boldface type or contrasting color.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in Section 38-71-540(a).

(1) General Rules

(a) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall have the right to continue coverage previously afforded by the policy and exercise any rights previously vested in the insured.

(b) "Guaranteed renewable insurance" means all individual insurance which grants an insured the right to continue the policy in force by the timely payment of premiums until at least age 65 or to eligibility for Medicare during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes except that the Commissioner may disapprove such increase in rates if he determines that the benefits provided in such policies are unreasonable in relation to the premium to be charged after the increase.

(c) "Noncancellable insurance" or "noncancellable and guaranteed renewable insurance" means all individual insurance which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy until at least age 65 or to eligibility for Medicare during which period the insurer has no right to make unilaterally any change in any provision of the policy while it is in force.

(d) "Nonrenewable for stated reasons only" or "Conditionally Renewable" means all individual insurance which limits the insurer's right of nonrenewal to reasons stated in the policy. The following are acceptable reasons, except that reasons 2 and 3 shall not be included in the same policy:

1. overinsurance in accordance with insurer's standards on file with the Commissioner;

2. discontinuance of all policies in the same class;

3. discontinuance of all policies issued on the same form in this State;

4. change of the insured's occupation to an occupation classified as more hazardous than the original occupation.

5. any other factor which would qualify as a valid and generally accepted insurance underwriting basis.

(e) In a policy covering both husband and wife the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

(f) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(g) If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such persons on a pro rata basis.

(h) In the event the insurer cancels, or refuses to renew, policies providing pregnancy benefits, the policy shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(i) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(j) Family coverage shall continue for any dependent child who is incapable of self sustaining employment due to intellectual disability or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(k) Any policy providing medical expense coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

(*l*) A policy may contain a provision relating to recurrent disabilities; provided however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

(m) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits due to accident, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(n) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(*o*) A company may not refuse to refund unearned premiums during a term for which premiums are paid. It may, however, base the amount of refund on a mode of premium payment more frequent than that of the term paid.

(p) Any accident-only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

(q) Termination of the policy shall be without prejudice to losses incurred for "one period of confinement", as defined, or to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(2) Basic Hospital Expense Coverage: "Basic Hospital Expense Coverage" is a policy of accident and health insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(a) daily hospital room and board in an amount not less than the lesser of 80% of the charges for semi-private room accommodations or $30.00 per day;

(b) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than the lesser of (i) 80% of the charges incurred up to at least $1,000.00 or (ii) ten times the daily hospital room and board benefits;

(c) hospital outpatient services consisting of hospital services on the day surgery is performed, hospital services rendered within 72 hours after accidental injury, in an amount not less than $50, and X-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an in-patient of the hospital in an amount not less than $100; and

(d) benefits provided under (a) and (b) of (2) above, may be provided subject to a combined deductible amount not in excess of $100.00.

(3) Basic Medical-Surgical Expense Coverage: "Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(a) Surgical Services:

1. in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale or surgical procedures, up to a maximum of at least $500.00 for any one procedure; or

2. not less than 80% of the reasonable charges.

(b) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the surgeon or the assistant surgeon performing the surgical services:

1. in an amount not less than 80% of the reasonable charges; or

2. 15% of the surgical service benefit.

(c) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty-one (21) days during one period of confinement.

(4) Hospital Confinement Indemnity Coverage: "Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $30.00 per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

(5) Major Medical Expense Coverage: "Major Medical Expense Coverage" is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $20,000.00; copayment by the covered person not to exceed

25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased to the amount of the benefits provided by such underlying insurance, for each covered person for at least:

(a) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than $70.00 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(b) miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than $1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(c) surgical services, prior to application of copayment percentage to a maximum of not less than $600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

(d) anesthesia services prior to application of the copayment percentage, for a maximum of not less than 15 percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(e) in-hospital medical services, prior to application of the copayment percentage, as defined in subdivision (3)(c) of G.

(f) out-of-hospital care prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(g) not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than $1,000:

1. In-hospital private duty graduate registered nurse services.
2. Convalescent nursing home care.
3. Diagnosis and treatment by a radiologist or physiotherapist.
4. Rental of special medical equipment, as defined by the insurer in the policy.
5. Artificial limbs or eyes, casts, splints, trusses or braces.
6. Treatment for functional nervous disorders, and mental and emotional disorders.
7. Out-of-hospital prescription drugs and medications.

(6) Disability Income Protection Coverage—This section does not apply to those policies providing business buyout coverage.

"Disability Income Protection Coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

(a) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to 62.

(b) Contains an elimination period no greater than:

1. Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less;

2. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

3. Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

(c) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth, or

miscarriage in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period.

(7) Accident Only Coverage: "Accident Only Coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000.00 and a single dismemberment amount shall be at least $500.00.

(8) Specified Disease and Specified Accident Coverage

(a) "Specified disease coverage" pays benefits for the diagnosis and/or treatment of a specifically named disease or diseases. Any such policy must meet the following general rules of subsection 1. In addition, policies providing coverage on an expense-incurred basis must meet the standards of subsection 2, while policies providing coverage on an indemnity basis must meet the standards of subsection 3.

1. General Rules.

The following rules shall apply to specified-disease coverages in addition to all other rules imposed by this regulation; in cases of conflict between the following and other rules, the following ones shall govern:

(i) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified-disease coverage under this section.

(ii) Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

(iii) Notwithstanding any other provision of this regulation, specified-disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

(iv) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

(v) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days.

(vi) Payments may be conditioned upon a covered person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(vii) Except for the uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.

(viii) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than forty-five (45) days prior to such diagnosis.

2. Expense-Incurred Policies.

(i) Coverage must be provided for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of $250.00 and an overall aggregate benefit limit of no less than $10,000 and a benefit period of not less than two (2) years for at least the following incurred expenses with no unreasonable inside limits:

(A) Hospital room and board and any other hospital furnished medical services or supplies;

(B) Treatment by a legally qualified physician or surgeon;

(C) Private duty services of a registered nurse (R.N.);

(D) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(E) Professional ambulance for local service to or from a local hospital;

(F) Blood transfusions, including expense incurred for blood donors;

(G) Drugs and medicines prescribed by a physician;

(H) The rental of an iron lung or similar mechanical apparatus;

(I) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(J) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease.

(ii) The policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

3. Indemnity Policies.

Coverage must be provided for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $25,000 payable at a daily rate not expected to produce a claim payment less than that which would be produced by a policy paying $50 a day while confined in a hospital with a benefit period of 500 days.

(b) "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000.00 for accidental death, $1,000.00 for double dismemberment and $500.00 for single dismemberment.

(9) Limited Benefit Health Insurance Coverage: "Limited Benefit Health Insurance Coverage" is any policy or contract, other than a policy or contract covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under G(2), (3), (4), (5), (6), (7), and (8). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section G(8) and shall not be offered for sale as a "Limited Coverage." Limited benefit policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section H(11) of this Regulation is completed and delivered as required by Section H(2) of this Regulation.

H. Required Disclosure Provisions.

(1) General Rules

(a) Each individual policy of accident and health insurance or hospital, medical or dental service corporation subscriber contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the increased benefits or coverage is required by law.

(c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such additional premium charge shall be clearly set forth separately in the policy or on the rider.

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

(e) If a policy contains any limitations with respect to pre-existing conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(f) Each accident only policy or a policy providing benefits for a specified disease only shall contain an appropriate prominent statement on the first page of the policy in boldface type or in contrasting color similar to the following, whichever is appropriate:

1. This is an accident only policy which does not pay benefits for a loss from sickness.

2. This is a specified disease policy which only provides benefits for a loss due to _____. It does not provide benefits for any other sickness or condition.

(g) All policies, except trip or travel ticket policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to policies issued pursuant to a direct response solicitation, the policy shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(h) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(i) If a policy contains a conversion privilege, it shall comply, in substance, with the following: the caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(j) Insurers issuing policies which provide hospital or medical expense coverage on either an expense incurred or indemnity basis to person(s) eligible for Medicare by reason of age, shall provide to the policyholder a medicare supplement buyer's guide in a form approved by the Commissioner. Delivery of the buyer's guide shall be made whether or not the policy qualifies as a medicare supplement coverage under Regulation 69-46. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application, and acknowledgment of receipt or certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon prior request but not later than at the time the policy is delivered. (NOTE: The NAIC Model Buyer's Guide is acceptable. Any substantially equivalent Buyer's Guide which has been approved by the Insurance Department of any other state may be used upon prior approval by the Commissioner.)

(k) Outlines of coverage delivered in connection with policies defined in this Regulation as Hospital Confinement Indemnity (G(4)), Specified Disease (G(8)), or Limited Benefit Health Insurance Coverages (G(9)) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of subsections H(6), H(10), and H(11), the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by the company.

(2) Outline of Coverage Requirements for Individual Coverages: No individual accident and health insurance policy or non-profit hospital, medical or dental service corporation subscriber contract subject to this regulation shall be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in Section H(3) through (11) is completed as to such policy or contract, and the outline is either: (a) delivered with the policy; or (b) delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

(a) for policies offered for sale as Medicare Supplement Coverage the outline is delivered to the applicant at the time application is made and, except for the direct response policy, acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer; and

(b) for all other policies, the outline is either:

1. delivered with the policy; or

2. delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of section G(2) shall be that statement contained in section H(3). The appropriate outline of coverage for policies providing coverage which meets the standards of both sections G(2) and (3) shall be the statement contained in section H(5). The appropriate outline of coverage for policies providing coverage which meets the standards of both sections G(2) and (5) or sections G(3) and (5) or sections G(2), (3), and (5) shall be the statement contained in section H(7).

An appropriate outline of coverage will be filed with each policy submitted for approval. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the Commissioner for prior approval.

(3) Basic Hospital Expense Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(2) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC HOSPITAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Basic Hospital Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital out-patient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(c) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

1. daily hospital room and board;

2. miscellaneous hospital services;

3. hospital out-patient services; and

4. other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(4) Basic Medical-Surgical Expense Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(3) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Basic Medical-Surgical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses in unlimited medical-surgical expenses.

(c) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

1. surgical services;
2. anesthesia services;
3. in-hospital medical services; and
4. other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(5) Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(2) and (3) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed.

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC HOSPITAL AND MEDICAL SURGICAL

EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy

provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOU POLICY CAREFULLY!

(b) Basic Hospital and Medical Surgical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

(c) A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

1. daily hospital room and board;
2. miscellaneous hospital services;
3. hospital out-patient services;
4. surgical services;
5. anesthesia services;
6. in-hospital medical services; and
7. other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(6) Hospital Confinement Indemnity Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(4) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS LOCAL TELEPHONE NUMBER: _____ (if available) _____

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Hospital Confinement Indemnity Coverage—Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(c) (A brief specific description of the benefits contained in this policy, in the following order:

1. daily benefit payable during hospital confinement; and
2. duration of benefit described in (a).)

(Note: The above description of benefits shall be stated clearly and concisely.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(f) (Any benefits provided in addition to the daily hospital benefit.)

(7) Major Medical Expense Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section G(5) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER _____ (if available) _____

MAJOR MEDICAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Major Medical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(c) (A brief specific description of the benefits, including dollar amount, contained in this policy, in the following order:

1. daily hospital room and board;
2. miscellaneous hospital services;
3. surgical services;
4. anesthesia services;
5. in-hospital medical services;
6. out-of-hospital care;
7. maximum dollar amount for covered charges; and
8. other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(8) Disability Income Protection Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(6) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

DISABILITY INCOME PROTECTION COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Disability Income Protection Coverage—Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(c) (A brief specific description of the benefits contained in this policy).

(Note: The above description of benefits shall be stated clearly and concisely.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(9) Accident Only Coverage (Outline of Coverage): An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(7) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS LOCAL TELEPHONE NUMBER: _____ (if available) _____

ACCIDENT ONLY COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) Accident Only Coverage—Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses due to sickness.

(c) (A brief specific description of the benefits contained in this policy.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (1)(*o*) of section G of this Regulation.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(10) Specified Disease or Specified Accident Coverage (Outline of Coverage): An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(8) of this Regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(b) (Specified Disease) (Specified Accident) Coverage—Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (Specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsections (1)(*o*) of section G of this Regulation.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(11) Limited Benefit Health Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of section G(2), (3), (4), (5), (6), (7), and (8) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS
LOCAL TELEPHONE NUMBER: _____ (if available) _____
LIMITED BENEFIT HEALTH COVERAGE
Policy Form Number _____
OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY!

(b) Limited Benefit Health Coverage—Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper

disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (1)(*o*) of section G of this Regulation.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(12) Limited Benefit Health Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of section G(2), (3), (4), (5), (6), (7), and (8) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

LIMITED BENEFIT HEALTH COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY!

(b) Limited Benefit Health Coverage—Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(Note: The above description of benefits shall be stated clearly a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (1)(*o*) of section G of this Regulation.)

(d) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (c) above.)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

I. Severability: Each provision of this Regulation is deemed to be severable and the determination that any provision is invalid for any reason shall not invalidate the remaining provisions of the Regulation.

HISTORY: Amended by State Register Volume 13, Issue No. 4, eff April 28, 1989.

Editor's Note

This regulation was adopted May 14, 1980.

69–34.1. Accident and Health Insurance Solicitation.

A. Table of Contents:

B . . . . . Purpose
C . . . . . Applicability and Scope
D . . . . . Definitions
E . . . . . Unfair and Deceptive Acts
F . . . . . Duplication of Insurance
G . . . . . Record Maintenance, Licensee Accountability and General Requirements
H . . . . . Severability
I . . . . . Effective Date

B. Purpose: The purpose of this regulation is to eliminate unfair and deceptive practices in the promotion, solicitation and sale of individual accident and health insurance policies to persons who are qualified for Medicare by reason of age and to persons who have a current Medicaid eligibility card.

C. Applicability and Scope: This Regulation shall apply only to promotions, solicitations, offers or sales of individual accident and health insurance policies to persons who are qualified for Medicare by reason of age or to persons who have a current Medicaid eligibility card. This Regulation shall not apply to conversion policies issued pursuant to a contractual conversion privilege, or to credit health insurance. This Regulation shall be in addition to any other applicable regulations previously adopted.

D. Definitions: As used in this Regulation, the following terms shall have the meanings indicated:

(1) ''Agent'' means any person licensed by the South Carolina Department of Insurance as an agent to sell accident and health insurance.

(2) ''Duplication of insurance'' means a transaction wherein new accident and health insurance is to be purchased and it is known or should be known to the licensee or the insurer, in the case of a direct response solicitation, that the new insurance will provide some of the benefits or coverages which the proposed insured already has under existing accident and health insurance.

(3) ''Over-insurance'' means ''duplication'' of insurance to such extent that the combination of the existing insurance and the proposed insurance would substantially exceed any loss reasonably expected to be incurred.

(4) ''Licensee'' means any person licensed as an agent, broker, or solicitor pursuant to South Carolina law.

(5) ''Policy'' means the entire contract between the insurer and the insured, including, but not limited to, the policy, certificate, riders, endorsements, amendments and the application which are required to be filed pursuant to Section 38-71-310.

(6) ''Sales materials'' means any and all promotional materials, policy applications, replacement forms, duplication forms, outline of coverage forms, or any other forms or informational material used in connection with the promotion, solicitation, or sale of accident and health insurance.

E. Unfair and Deceptive Acts:

(1) No person shall engage in any unfair, deceptive, misleading, or unreasonably confusing practice in the promotion, solicitation or sale of individual accident and health insurance.

(2) The following acts and practices shall be deemed prima facie evidence of a violation of this Regulation:

(a) Any act tending to induce an applicant or other person to over-insure;

(b) Encouraging an applicant to omit pertinent underwriting information from an application for accident and health insurance;

(c) Any act tending to induce a prospective insured to sign a blank or incomplete application or form;

(d) Failure to disclose upon initial contact with a prospective applicant the licensee's affiliation with an insurance company;

(e) Any representations, expressed or implied, unless the licensee has been specifically authorized in writing by the organization, that the licensee is affiliated with or authorized by any civic, social, or other non-governmental organization;

(f) Any representation, expressed or implied, that the licensee is affiliated with or authorized by any governmental agency or that he has access to any information from any such agency that is not generally available to the public;

(g) Making any false or misleading statements as to the length of time an insurance product may or may not be available;

(h) The sale of any policy that has not been submitted to and approved by the Commissioner;

(i) The sale of Medicare supplement insurance to any person not eligible for Medicare;

(j) The sale of any accident and health insurance to any person without asking if the person has a current Medicaid eligibility card;

(k) The sale of any accident and health insurance to any person who indicates he has a current Medicaid eligibility card;

(*l*) Falsely answering any question or signing any certification in an application or in any other form required to be completed by the licensee;

(m) Failure to report, within seven business days, the full amount of any premium or partial premium collected from an applicant;

(n) Failure to deliver, within seven business days, any policy sent to him for delivery to an applicant;

(*o*) The taking of an application without inquiring and recording the reply as to whether the proposed insurance will duplicate any insurance then in force;

(p) Making any inquiry in such manner as to invite a response contrary to fact; or

(q) The taking of an application for duplicate insurance without a full disclosure of the effect that each policy will have on the other with respect to the amount payable in the event of a claim covered by both policies.

F. Duplication of Insurance:

(1) All applications involved in the sale of individual accident and health insurance shall include a question designed to elicit information regarding the existence of any accident and health insurance on any proposed insured and shall obtain a statement, dated and signed by the applicant, indicating whether any accident and health insurance is presently in force, the type and amount of the insurance, the names of the companies which issued the insurance and, where possible, the policy number.

(2) No individual accident and health insurance which duplicates coverage shall be issued to an applicant unless a signed and dated "Duplication of Insurance Form" is submitted with the application.

(3) The "Duplication of Insurance Form" shall comply with the following form and be separate and apart from all other forms:

I understand that the insurance I am applying for will duplicate coverage I already have. Even so, I still believe I need this new insurance

_____	_____
(Witness)	(Signature of Applicant)
	_____
	(Date)

(4) In the case of direct response insurance, the following statement, separate and apart from all other statements, shall be mailed to the insured with the new policy:

"This policy duplicates coverage you already have."

(5) A copy of the "Duplication of Insurance Form" shall be retained by the insurer.

G. Record Maintenance, Licensee Accountability, and General Requirements:

(1) Any and all materials used in connection with the promotion, solicitation, or sale of individual accident and health insurance shall be maintained on file by the insurer for a period of three years following the date of its last authorized use.

(2) No licensee or insurer shall use any sales and promotional material not issued or approved by and on file with the insurer.

(3) Copies of all sales and promotional material shown to the applicant shall be left by the licensee with any person who purchases accident and health insurance from the licensee. If an audio-visual presentation is made, a copy of the script left with the applicant will be deemed to satisfy this requirement.

(4) Insurers shall maintain records relating to agents involved in the sale of accident and health insurance so as to permit retrieval of the following information in a reasonable period of time:

(a) Number, type, and nature of consumer complaints, on each agent including those received over the telephone;

(b) Number, type, and nature of forms and applications completed with improper or inaccurate underwriting information;

(c) Number, type, and nature of all policies which lapse within five years of issue showing total period of coverage; and

(d) All policy applications rejected showing the reason for rejection.

H. Severability: Each provision of this Regulation is deemed to be severable and the determination that any provision is invalid for any reason shall not invalidate the remaining provisions of the Regulation.

I. Effective Date: This Regulation shall become effective six months after adoption by the General Assembly and final publication in the State Register.

Editor's Note

This regulation was adopted May 14, 1980.

69–34.2. Replacement of Accident and Health Insurance.

A. Table of Contents:

B . . . . . Purpose
C . . . . . Applicability and Scope
D . . . . . Definitions
E . . . . . Replacement
F . . . . . Replace After Indication of No Replacement
G . . . . . Severability
H . . . . . Effective Date

B. Purpose: The purpose of this regulation is to eliminate unfair and deceptive practices in the replacement of individual accident and health insurance policies that insure persons who are eligible for Medicare by reason of age and to persons who have a current medicaid eligibility card. medicaid eligibility card.

C. Applicability and Scope: This Regulation shall apply only to solicitations and sale of individual accident and health insurance policies to persons who are eligible for Medicare by reason of age or to persons who have a current medicaid eligibility card. This Regulation shall not apply to credit health insurance. This Regulation shall be in addition to any other applicable regulations previously adopted.

D. Definitions: As used in this Regulation, the following terms shall have the meanings indicated:

(1) "Agent" means any person licensed by the South Carolina Department of Insurance as an agent to sell accident and health insurance.

(2) "Licensee" means any person licensed as an agent, broker, or solicitor pursuant to South Carolina law.

(3) "Policy" means the entire contract between the insurer and the insured, including, but not limited to, the policy, certificate, riders, endorsements, amendments and the application which are required to be filed pursuant to Section 38-71-310.

(4) "Replacement" means a transaction wherein individual accident and health insurance is to be purchased and it is known or should be known to the licensee or the insurer, in the case of a direct response solicitation, that previously existing accident and health insurance has been, or will be, lapsed, cancelled or otherwise terminated as a result.

(5) "Sales materials" means any and all promotional materials, policy applications, replacement forms, duplication forms, outline of coverage forms, or any other forms or informational material used in connection with the promotion, solicitation, or sale of accident and health insurance.

E. Replacement:

(1) All applications involved in the sale of individual accident and health insurance shall include a question designed to elicit information regarding the existence of any accident and health insurance on any proposed insured and inquire as to whether any such insurance will be replaced by the insurance to be issued.

(2) Upon determining that a sale will involve replacement, a licensee or insurer other than a direct response insurer shall at the time of the application furnish the applicant with the notice

described in (3) below. One copy of such notice shall be delivered to the applicant and an additional copy signed by the applicant shall be submitted with the application and retained by the insurer.

In addition, the licensee shall furnish the applicant with a complete comparison in writing of the benefits afforded by the new policy and the policy to be replaced. Such comparison shall include but not be limited to the benefits contained in the two policies, the renewability provisions of the two policies, and the respective definitions of pre-existing illnesses or diseases.

A direct response insurer shall, upon issuance of the policy, deliver to the applicant the notice described in (4) below. The comparison statement and the notice will not be required if the insurance to be replaced is accident only or a single premium nonrenewable policy.

(3) The notice required by (2) above for a licensee or insurer other than a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy issued by (insert Company Name) Insurance Company. 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. In particular, study the comparison statement which your agent is required to furnish you upon taking your application.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) 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 interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) 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. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

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

_____

(Date)

_____

(Applicant's Signature)

(4) The notice required by (3) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for

benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) 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 interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (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. You should carefully check the application and write the company immediately if any information is not correct, or if any past medical history has been left out of the application before letting your other policy lapse.

_____

(Company Name)

F. Replacement After Indication of No Replacement.

Policyholders have the right to replace existing accident and health insurance after indicating in or as a part of applications for new insurance that such is not their intention; however, patterns of such action by policyholders on the same agent shall be evidence of the agent's knowledge that replacement was intended in connection with such transactions and indicate that the agent intended to violate the statute.

G. Severability: Each provision of this Regulation is deemed to be severable and the determination that any provision is invalid for any reason shall not invalidate the remaining provisions of the Regulation.

H. Effective Date: This Regulation shall become effective six months after adoption by the General Assembly and final publication in the State Register.

Editor's Note

This regulation was adopted May 14, 1980.

69–36. Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Under 1980 CSO and CET Mortality Tables.

(Statutory Authority: 1976 Code §§ 38-3-110, 38-63-600(8)(f))

SECTION 1. Purpose.

The purpose of this regulation is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this regulation.

SECTION 2. Definitions.

A. As used in this regulation, "1980 CSO Table, with or without Ten-Year Select Morality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors.

B. As used in this regulation, "1980 CSO Table (M), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

C. As used in this regulation, "1980 CSO Table (F), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

D. As used in this regulation, "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to

Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

E. As used in this regulation, "1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

F. As used in this regulation, "1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

G. As used in this regulation, "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" means the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the National Association of Insurance Commissioners in December, 1983.

SECTION 3. Options.

For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of Section 38-63-600(11) for that policy form,

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

(ii) a mortality table which is of the same blend as used in (i) but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table

for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

SECTION 3A. Alternate Rule.

In determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of Section 38-63-600(11) for that policy form, in addition to the mortality tables that may be used according to Section 3,

(i) a mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without ten-year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(ii) a mortality table which is of the same blend as used in (i) but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 CET Table.

SECTION 4. Unfair Discrimination.

It shall not be a violation of any provision of Chapter 57 of Title 38 of the 1976 Code for an insurer to issue the same kind of policy of life insurance on both a sex distinct and sex neutral basis.

SECTION 5. Separability.

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

SECTION 6. Effective Date.

The effective date of this regulation is August 1, 1983.

HISTORY: Amended by State Register Volume 9, Issue No. 6, eff June 24, 1988.

Code Commissioner's Note

Pursuant to 2011 Act No. 47, § 14(B), the Code Commissioner substituted "intellectual disability" for "mental retardation" and "person with intellectual disability" or "persons with intellectual disability" for "mentally retarded".

69–37. Annuity Mortality Tables For Use In Determining Reserve Liabilities For Annuities.

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Appendix IV. Projection Scale G2, Male, Age Nearest Birthday

Section 1. Authority

This regulation is promulgated by the Director of Insurance pursuant to Section 38–9–180 of the South Carolina Code.

Section 2. Purpose

The purpose of this regulation is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a," the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, the 2012 Individual Annuity Reserving (2012 IAR) Table and the 1994 Group Annuity Reserving (1994 GAR) Table.

Section 3. Definitions

A. As used in this regulation "1983 Table "a," means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.

B. As used in this regulation "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

C. As used in this regulation "1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force. The 1994 GAR Table is included in the report on pages 865–919 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

D. As used in this regulation "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research. The Annuity 2000 Table is included in the report on pages 211–249 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

E. As used in this regulation, "Period table" means a table of mortality rates applicable to a given calendar year (the Period).

F. As used in this regulation, "Generational mortality table" means a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period table and a projection scale containing rates of mortality improvement.

G. As used in this regulation "2012 IAR Table" means that Generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, qx^{2012+n},

derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in Section 5.

H. As used in this regulation, "2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table" means the Period table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices 1–2.

I. As used in this regulation, "Projection Scale G2 (Scale G2)" is a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices 3–4.

Section 4. Individual Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this section, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1979.

B. Except as provided in Subsection C of this section, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1986.

C. Except as provided in Subsection D of this section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2001.

D. Except as provided in Subsection E of this section, the 2012 IAR Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2015.

E. The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 2001, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(1) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(2) Settlements involving similar actions such as workers' compensation claims; or

(3) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Section 5. Application of the 2012 IAR Mortality Table

In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

$$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$$

The resulting q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate.

For example, for a male age 30, $q_x^{2012} = 0.741$.

$q_x^{2013} = 0.741 * (1 - 0.010) \wedge 1 = 0.73359$, which is rounded to 0.734.

$q_x^{2014} = 0.741 * (1 - 0.010) \wedge 2 = 0.7262541$, which is rounded to 0.726.

A method leading to incorrect rounding would be to calculate q_x^{2014} as $q_x^{2013} * (1 - 0.010)$, or 0.734 * 0.99 = 0.727.

It is incorrect to use the already rounded q_x^{2013} to calculate q_x^{2014}.

Section 6. Group Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this section, the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of

valuation for an annuity or pure endowment purchased on or after January 1, 1979 under a group annuity or pure endowment contract.

B. Except as provided in Subsection C of this section, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1986 under a group annuity or pure endowment contract.

C. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 2001 under a group annuity or pure endowment contract.

Section 7. Application of the 1994 GAR Table

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 +" n) is calculated as follows:

$$q_x^{1994+"n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} and AA_xs are as specified in the 1994 GAR Table.

Section 8. Separability

If any provision of this regulation or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

APPENDIX I

2012 IAM Period Table Female, Age Nearest Birthday

AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$
0	1.621	30	0.300	60	3.460	90	88.377
1	0.405	31	0.321	61	3.916	91	97.491
2	0.259	32	0.338	62	4.409	92	107.269
3	0.179	33	0.351	63	4.933	93	118.201
4	0.137	34	0.365	64	5.507	94	130.969
5	0.125	35	0.381	65	6.146	95	146.449
6	0.117	36	0.402	66	6.551	96	163.908
7	0.110	37	0.429	67	7.039	97	179.695
8	0.095	38	0.463	68	7.628	98	196.151
9	0.088	39	0.504	69	8.311	99	213.150
10	0.085	40	0.552	70	9.074	100	230.722
11	0.086	41	0.600	71	9.910	101	251.505
12	0.094	42	0.650	72	10.827	102	273.007
13	0.108	43	0.697	73	11.839	103	295.086
14	0.131	44	0.740	74	12.974	104	317.591
15	0.156	45	0.780	75	14.282	105	340.362
16	0.179	46	0.825	76	15.799	106	362.371
17	0.198	47	0.885	77	17.550	107	384.113
18	0.211	48	0.964	78	19.582	108	400.000
19	0.221	49	1.051	79	21.970	109	400.000
20	0.228	50	1.161	80	24.821	110	400.000
21	0.234	51	1.308	81	28.351	111	400.000
22	0.240	52	1.460	82	32.509	112	400.000
23	0.245	53	1.613	83	37.329	113	400.000
24	0.247	54	1.774	84	42.830	114	400.000
25	0.250	55	1.950	85	48.997	115	400.000
26	0.256	56	2.154	86	55.774	116	400.000
27	0.261	57	2.399	87	63.140	117	400.000
28	0.270	58	2.700	88	71.066	118	400.000
29	0.281	59	3.054	89	79.502	119	400.000
						120	1000.000

APPENDIX II

2012 IAM Period Table Male, Age Nearest Birthday

AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$	AGE	$1000\ q_x^{2012}$
0	1.605	30	0.741	60	5.096	90	109.993
1	0.401	31	0.751	61	5.614	91	123.119
2	0.275	32	0.754	62	6.169	92	137.168
3	0.229	33	0.756	63	6.759	93	152.171
4	0.174	34	0.756	64	7.398	94	168.194
5	0.168	35	0.756	65	8.106	95	185.260
6	0.165	36	0.756	66	8.548	96	197.322
7	0.159	37	0.756	67	9.076	97	214.751
8	0.143	38	0.756	68	9.708	98	232.507
9	0.129	39	0.800	69	10.463	99	250.397
10	0.113	40	0.859	70	11.357	100	268.607
11	0.111	41	0.926	71	12.418	101	290.016
12	0.132	42	0.999	72	13.675	102	311.849
13	0.169	43	1.069	73	15.150	103	333.962
14	0.213	44	1.142	74	16.860	104	356.207
15	0.254	45	1.219	75	18.815	105	380.000
16	0.293	46	1.318	76	21.031	106	400.000
17	0.328	47	1.454	77	23.540	107	400.000
18	0.359	48	1.627	78	26.375	108	400.000
19	0.387	49	1.829	79	29.572	109	400.000
20	0.414	50	2.057	80	33.234	110	400.000
21	0.443	51	2.302	81	37.533	111	400.000
22	0.473	52	2.545	82	42.261	112	400.000
23	0.513	53	2.779	83	47.441	113	400.000
24	0.554	54	3.011	84	53.233	114	400.000
25	0.602	55	3.254	85	59.855	115	400.000
26	0.655	56	3.529	86	67.514	116	400.000
27	0.688	57	3.845	87	76.340	117	400.000
28	0.710	58	4.213	88	86.388	118	400.000
29	0.727	59	4.631	89	97.634	119	400.000
						120	1000.000

APPENDIX III

Projection Scale G2 Female, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	0.010	30	0.010	60	0.013	90	0.006
1	0.010	31	0.010	61	0.013	91	0.006
2	0.010	32	0.010	62	0.013	92	0.005
3	0.010	33	0.010	63	0.013	93	0.005
4	0.010	34	0.010	64	0.013	94	0.004
5	0.010	35	0.010	65	0.013	95	0.004
6	0.010	36	0.010	66	0.013	96	0.004
7	0.010	37	0.010	67	0.013	97	0.003
8	0.010	38	0.010	68	0.013	98	0.003
9	0.010	39	0.010	69	0.013	99	0.002
10	0.010	40	0.010	70	0.013	100	0.002
11	0.010	41	0.010	71	0.013	101	0.002
12	0.010	42	0.010	72	0.013	102	0.001
13	0.010	43	0.010	73	0.013	103	0.001
14	0.010	44	0.010	74	0.013	104	0.000
15	0.010	45	0.010	75	0.013	105	0.000
16	0.010	46	0.010	76	0.013	106	0.000
17	0.010	47	0.010	77	0.013	107	0.000
18	0.010	48	0.010	78	0.013	108	0.000
19	0.010	49	0.010	79	0.013	109	0.000
20	0.010	50	0.010	80	0.013	110	0.000
21	0.010	51	0.010	81	0.012	111	0.000

22	0.010	52	0.011	82	0.012	112	0.000
23	0.010	53	0.011	83	0.011	113	0.000
24	0.010	54	0.011	84	0.010	114	0.000
25	0.010	55	0.012	85	0.010	115	0.000
26	0.010	56	0.012	86	0.009	116	0.000
27	0.010	57	0.012	87	0.008	117	0.000
28	0.010	58	0.012	88	0.007	118	0.000
29	0.010	59	0.013	89	0.007	119	0.000
						120	0.000

APPENDIX IV

Projection Scale G2 Male, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	0.010	30	0.010	60	0.015	90	0.007
1	0.010	31	0.010	61	0.015	91	0.007
2	0.010	32	0.010	62	0.015	92	0.006
3	0.010	33	0.010	63	0.015	93	0.005
4	0.010	34	0.010	64	0.015	94	0.005
5	0.010	35	0.010	65	0.015	95	0.004
6	0.010	36	0.010	66	0.015	96	0.004
7	0.010	37	0.010	67	0.015	97	0.003
8	0.010	38	0.010	68	0.015	98	0.003
9	0.010	39	0.010	69	0.015	99	0.002
10	0.010	40	0.010	70	0.015	100	0.002
11	0.010	41	0.010	71	0.015	101	0.002
12	0.010	42	0.010	72	0.015	102	0.001
13	0.010	43	0.010	73	0.015	103	0.001
14	0.010	44	0.010	74	0.015	104	0.000
15	0.010	45	0.010	75	0.015	105	0.000
16	0.010	46	0.010	76	0.015	106	0.000
17	0.010	47	0.010	77	0.015	107	0.000
18	0.010	48	0.010	78	0.015	108	0.000
19	0.010	49	0.010	79	0.015	109	0.000
20	0.010	50	0.010	80	0.015	110	0.000
21	0.010	51	0.011	81	0.014	111	0.000
22	0.010	52	0.011	82	0.013	112	0.000
23	0.010	53	0.012	83	0.013	113	0.000
24	0.010	54	0.012	84	0.012	114	0.000
25	0.010	55	0.013	85	0.011	115	0.000
26	0.010	56	0.013	86	0.010	116	0.000
27	0.010	57	0.014	87	0.009	117	0.000
28	0.010	58	0.014	88	0.009	118	0.000
29	0.010	59	0.015	89	0.008	119	0.000
						120	0.000

HISTORY: Amended by State Register Volume 25, Issue No. 4, eff April 27, 2001; State Register Volume 38, Issue No. 6, Doc. No. 4453, eff June 27, 2014.

Editor's Note

This regulation was adopted August 24, 1984.

69–38. Regulation Permitting Smoker/Nonsmoker Mortality Tables for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits.

(Statutory Authority: 1976 Code §§ 38-3-110, 38-9-180, 38-63-600(8)(f))

SECTION 1. Purpose.

The purpose of this regulation is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

SECTION 2. Definitions.

A. As used in this regulation, "1980 CSO Table, with or without Ten-Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

B. As used in this regulation, "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

C. As used in this regulation, "1958 CSO Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

D. As used in this regulation, "1958 CET Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in the model as the Commissioners 1958 Extended Term Insurance Table.

E. As used in this regulation, the phrase "smoker and nonsmoker mortality tables" refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in A through D of this section which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance Department staff and recommended by the NAIC Technical Staff Actuarial Group.

F. As used in this regulation, the phrase "composite mortality tables" refers to the mortality tables defined in A through D of this section as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

SECTION 3. Alternate Tables.

A. For any policy of insurance delivered or issued for delivery in this State after the operative date of Section 37-63-600 for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in Section 4 of this regulation,

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

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

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Provided that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

Provided further that the substitution of the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

B. For any policy of insurance delivered or issued for delivery in this State after the operative date of Section 38-63-600 for that policy form, at the option of the company and subject to the conditions stated in Section 4 of this regulation,

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

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

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

SECTION 4. Conditions.

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

(i) use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits,

(ii) use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Section 38-9-180 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or

(iii) use smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

SECTION 5. Separability.

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

SECTION 6. Effective Date.

This regulation is effective on the date of its approval and is applicable to all business issued on January 1 and afterward of the year of approval.

Editor's Note

This regulation was adopted June 28, 1985.

69–39. Annuity Disclosure Regulation.

Section 1. Purpose

A. The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

B. The regulation does not prohibit the use of additional material which is not in violation of this regulation or any other South Carolina statute or regulation.

Section 2. Scope

This regulation applies to all group and individual annuity contracts and certificates except:

A. Registered or non-registered variable annuities or other registered products;

B. Immediate and deferred annuities that contain no non-guaranteed elements;

C. (1) Annuities used to fund:

(a) An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(c) A governmental or church plan defined in Section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(2) Notwithstanding Paragraph (1), the regulation shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pre-tax or aftertax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

D. Structured settlement annuities;

E. Charitable gift annuities; and

F. Funding agreements.

Section 3. Definitions

For the purposes of this regulation:

A. "Buyer's Guide" means the current Buyer's Guide to Fixed Deferred Annuities, including any appendices thereto, adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the Director of the Department of Insurance.

B. "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.

C. "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

D. "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

E. "Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

F. "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

G. "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

H. "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

I. "Structured settlement annuity" means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) of the Internal Revenue Code but for the fact that it is not owned by an assignee under a qualified assignment.

Section 4. Standards for the Disclosure Document and Buyer's Guide

A.(1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and a copy of the Buyer's Guide.

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than five (5) business days after the completed application is received by the insurer.

(a) With respect to an application received as a result of a direct solicitation through the mail:

(i) Providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business days after receipt of the application.

(ii) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b) With respect to an application received via the Internet:

(i) Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business days after receipt of the application.

(ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the Department for a free Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free Buyer's Guide.

(3) Where the Buyer's Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look period shall run concurrently with any other free look period provided under state law or regulation.

B. At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity.

(2) The insurer's name and address.

(3) A description of the contract and its benefits, emphasizing its long-term nature, including the following where appropriate:

(a) The guaranteed, non-guaranteed and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate;

(b) An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(c) Periodic income options both on a guaranteed and non-guaranteed basis;

(d) Any value reductions caused by withdrawals from or surrender of the contract;

(e) How values in the contract can be accessed;

(f) The death benefit, if available and how it will be calculated;

(g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(h) The impact of any rider, such as a long-term care rider.

(4) The specific dollar amount or percentage charges and fees with an explanation of how they apply.

(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

Section 5. Report to Contract Owners

For annuities in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. The beginning and end date of the current report period;

B. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

D. The amount of outstanding loans, if any, as of the end of the current report period.

Section 6. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of South Carolina Code Ann. § 38–57–10 et seq.

Section 7. Severability

If any section or portion of a section of this regulation, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this regulation, or the applicability of its provisions to other persons, shall not be affected.

Section 8. Effective Date

This regulation shall become effective six months following final publication in the State Register and shall apply to contracts sold on or after the effective date.

HISTORY: Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

69–40. Life Insurance Policy Illustration Rules.

Section 1. Purpose

The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

Section 2. Applicability and Scope

This regulation applies to all group and individual life insurance policies and certificates except:

A. Variable life insurance;

B. Individual and group annuity contracts;

C. Credit life insurance; or

D. Life insurance policies with no illustrated death benefits on any individual exceeding $10,000.

Section 3. Definitions

For the purposes of this regulation:

A. "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

B. "Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

C. "Currently payable scale" means a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five (95) days.

D. "Disciplined current scale" means a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

(1) Are consistent with all provisions of this regulation;

(2) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(3) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(4) Do not permit assumed expenses to be less than minimum assumed expenses.

E. "Generic name" means a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

F. "Guaranteed elements" and "non-guaranteed elements"

(1) "Guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

(2) "Non-guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

G. "Illustrated scale" means a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(1) The disciplined current scale; or

(2) The currently payable scale.

H. "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years and that is one of the three (3) types defined below:

(1) "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

(2) "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this regulation, and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

(3) "In force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

I. "Illustration actuary" means an actuary meeting the requirements of Section 10 who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

J. "Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting as defined in this regulation, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 percent policy persistency thereafter.

K.(1) "Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(a) Fully allocated expenses;

(b) Marginal expenses; and

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the NAIC or the Director.

(2) Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

L. "Non-term group life" means a group policy or individual policies of non-term life insurance issued to insure members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative;

(2) Some portion of the premium is paid by the group or through payroll deduction; and

(3) Group underwriting or simplified underwriting is used.

M. "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

N. "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

O. "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

Section 4. Policies to Be Illustrated

A. Each insurer marketing policies to which this regulation is applicable shall notify the Director whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this regulation, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this regulation, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the Director.

B. Except in the case of replacement, if the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

C. If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this regulation is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

D. Potential enrollees of non-term group life subject to this regulation shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this regulation, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the policy or certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it.

Section 5. General Rules and Prohibitions

A. An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this regulation, be clearly labeled "life insurance illustration" and contain the following basic information:

(1) Name of insurer;

(2) Name and business address of agent or insurer's authorized representative, if any;

(3) Name, age and sex of proposed insured, except where a composite illustration is permitted under this regulation;

(4) Underwriting or rating classification upon which the illustration is based;

(5) Generic name of policy, the company product name, if different, and form number;

(6) Initial death benefit; and

(7) Dividend option election or application of non-guaranteed elements, if applicable.

B. When using an illustration in the sale of a life insurance policy, an insurer or its agents or other authorized representatives shall not:

(1) Represent the policy as anything other than a life insurance policy;

(2) Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(3) State or imply that the payment or amount of non-guaranteed elements is guaranteed;

(4) Use an illustration that does not comply with the requirements of this regulation;

(5) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

(6) Provide an applicant with an incomplete illustration;

(7) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

(8) Use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;

(9) Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or

(10) Use an illustration that is not "self-supporting."

C. If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

Section 6. Standards for Basic Illustrations

A. Format. A basic illustration shall conform with the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared.

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").

(3) The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

(5) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

(6) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(7) If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed.

(8) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page one for guaranteed elements.")

(9) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

(10) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

(11) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

(12) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be more or less favorable.

(13) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

(14) If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

B. Narrative Summary. A basic illustration shall include the following:

(1) A brief description of the policy being illustrated, including a statement that it is a life insurance policy;

(2) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

(3) A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

(4) Identification and a brief definition of column headings and key terms used in the illustration; and

(5) A statement containing in substance the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

C. Numeric Summary.

(1) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10) and twenty (20) and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).

(a) Policy guarantees;

(b) Insurer's illustrated scale;

(c) Insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

(i) Dividends at fifty percent (50%) of the dividends contained in the illustrated scale used;

(ii) Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(iii) All non-guaranteed charges, including but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

(2) In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three (3) bases.

D. Statements. Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this regulation.

(1) A statement to be signed and dated by the applicant or policy owner reading as follows: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."

(2) A statement to be signed and dated by the insurance agent or other authorized representative of the insurer reading as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

E. Tabular Detail.

(1) A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(a) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(b) The corresponding guaranteed death benefit, as provided in the policy; and

(c) The corresponding guaranteed value available upon surrender, as provided in the policy.

(2) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(3) Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

Section 7. Standards for Supplemental Illustrations

A. A supplemental illustration may be provided so long as:

(1) It is appended to, accompanied by or preceded by a basic illustration that complies with this regulation;

(2) The non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(3) It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed; and

(4) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

B. The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

Section 8. Delivery of Illustration and Record Retention

A.(1) If a basic illustration is used by an insurance agent or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this regulation, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant.

(2) If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of this regulation, shall be labeled "Revised Illustration" and shall be signed and dated by the applicant or policy owner and agent or other authorized representative of the insurer

no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

B.(1) If no illustration is used by an insurance agent or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the agent or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

(2) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

C. If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

D. A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued.

Section 9. Annual Report; Notice to Policy Owners

A. In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(1) For universal life policies, the report shall include the following:

(a) The beginning and end date of the current report period;

(b) The policy value at the end of the previous report period and at the end of the current report period;

(c) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(d) The current death benefit at the end of the current report period on each life covered by the policy;

(e) The net cash surrender value of the policy as of the end of the current report period;

(f) The amount of outstanding loans, if any, as of the end of the current report period; and

(g) For fixed premium policies:

If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(h) For flexible premium policies:

If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

(2) For all other policies, where applicable:

(a) Current death benefit;

(b) Annual contract premium;

(c) Current cash surrender value;

(d) Current dividend;

(e) Application of current dividend; and

(f) Amount of outstanding loan.

(3) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

B. If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently: "**IMPORTANT POLICY OWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

C. Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of Sections 5A, 5B, 6A and 6E. No signature or other acknowledgment of receipt of this illustration shall be required.

D. If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

Section 10. Annual Certifications

A. The board of directors of each insurer shall appoint one or more illustration actuaries.

B. The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this regulation.

C. The illustration actuary shall:

(1) Be a member in good standing of the American Academy of Actuaries;

(2) Be familiar with the standard of practice regarding life insurance policy illustrations;

(3) Not have been found by the Director, following appropriate notice and hearing to have:

(a) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(d) Resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

(4) Not fail to notify the Director of any action taken by a Director of another state similar to that under Paragraph (3) above;

(5) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification; and

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(a) Fully allocated expenses;

(b) Marginal expenses; or

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the NAIC or the Director.

D.(1) The illustration actuary shall file a certification with the board and with the Director:

(a) Annually for all policy forms for which illustrations are used; and

(b) Before a new policy form is illustrated.

(2) If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the Director promptly.

E. If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the Director promptly of his or her inability to certify.

F. A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(1) That the illustration formats meet the requirements of this regulation and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in Subsection C(6) of this section.

G. The annual certifications shall be provided to the Director each year by a date determined by the insurer.

H. If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the Director of that fact promptly and disclose the reason for the change.

Section 11. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or agent that violates a requirement of this regulation shall be guilty of a violation of South Carolina Code Ann. § 38-2-10 et seq., and shall be subject to administrative penalties as set forth in South Carolina Code Ann. § 38-2-10.

Section 12. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 13. Effective Date

This regulation shall become effective July 1, 1997, and shall apply to policies sold on or after the effective date. This regulation shall apply to non-term group certificates issued on or after the anniversary date immediately following the effective date.

HISTORY: Added by State Register Volume 21, Issue No. 6, Part 2, eff July 1, 1997.

69–40.1. Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities.

Section 1. Purpose

The purpose of this regulation is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

Section 2. Scope

This regulation shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by an insurance producer.

Section 3. Definition

For purposes of this regulation, "insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance, including annuities.

Section 4. Prohibited Uses of Senior-Specific Certifications and Professional Designations

A.(1) It is an unfair and deceptive act or practice in the business of insurance within the meaning of Chapter 57 of the 1976 Code of Laws of South Carolina, as amended, for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

(2) The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(a) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(b) Use of a nonexistent or self-conferred certification or professional designation;

(c) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the insurance producer using the certification or designation does not have; and

(d) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

(i) Is primarily engaged in the business of instruction in sales or marketing;

(ii) Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;

(iii) Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

(iv) Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

B. There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for purposes of subsection A(2)(d) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the organization or the certification or designation in question has been accredited by:

(1) The American National Standards Institute (ANSI);

(2) The National Commission for Certifying Agencies; or

(3) Any organization that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

C. In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

(1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "advisor," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

D.(1) For purposes of this regulation, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

(a) Indicates seniority or standing within the organization; or

(b) Specifies an individual's area of specialization within the organization.

(2) For purposes of this subsection, financial services regulatory agency includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

Section 5. Effective Date

This regulation shall become effective upon final publication in the *State Register*.

HISTORY: Added by State Register Volume 34, Issue No. 5, eff May 28, 2010.

69–41. Prepaid Dental Service.

(Statutory Authority: 1976 Code §§ 38-3-110, 38-1-20(1), 1-23-10)

A. Introduction.

In Act No. 40 of 1979, the South Carolina General Assembly amended S. C. Code § 38-5-20(b)(1976) [recodified as § 38-1-20(1)], so as to add "prepaid dental service" to the definition of "accident and health insurance." The effect of this amendment was to require any person or entity which offers, sells, delivers or issues for delivery prepaid dental service contracts in this State to be licensed as an insurance company to transact an accident and health insurance business. The Act further amended S. C. Code § 38-57-190(2) (1976), so as to permit the granting of preferences or distinctions to particular groups under prepaid dental service plans.

Unfortunately, the Act did not define the phrase "prepaid dental service." Over the years, it has become increasingly clear that a definition of what constitutes "prepaid dental service" must be established. Under the broadest reading of the phrase, even the most informal retainer-type of arrangement between an individual dentist and an individual patient could be deemed to be "prepaid dental service," if there was any payment of fees prior to the rendering of dental services. In such a case, the individual dentist would be required to be licensed as an accident and health insurance company and subjected to the full range of regulatory and tax laws applicable to insurance companies. The Chief Insurance Commissioner simply does not believe that this was the result intended by the General Assembly.

One of the primary purposes of the insurance regulatory laws is the assurance of the solvency and soundness of insurance companies. To the extent that a person or entity contractually promises to arrange for the provision of, or reimbursement for, dental services to be performed by another person who is a licensed dentist, and further collects money from the public in consideration of such promises, the solvency concerns of the insurance regulatory laws are implicated. Under this scenario, the person collecting the money and making the promises (i.e., the promisor) is not the same person who is performing the dental services. In order for the promisor to fulfill his contractual obligations, it is imperative that he at all times have sufficient funds available to compensate dentists performing the services and/or reimburse contractholders for dental expenses they incur. The assurance that those funds will be available to fulfill contractual obligations goes to the very heart of solvency regulation under the insurance laws.

By contrast, where the promisor is the dentist performing the services, the solvency concerns expressed above are not present. So long as the dentist has the requisite knowledge, skill and competence to practice dentistry, as well as a valid license to do so, the dentist can fulfill his contractual obligations to his contractholder/patient, regardless of what his financial condition is. Consequently, the State does not have the same interest in solvency protection that it does in the circumstances previously described.

It is therefore the purpose of this regulation to define the phrase "prepaid dental service" as used in § 38-1-20(1), so as to clearly identify those plans and their sponsors which are subject to licensing and regulation by the Chief Insurance Commissioner.

B. "Prepaid dental service" defined.

(1) Definition.

"Prepaid dental service" means a contract, plan or agreement whereby one undertakes, in consideration of a specified payment, to provide for the rendering of, or reimbursement for, dental services during a specified interval of time, where such dental services are performed by a person duly licensed to practice dentistry in the jurisdiction in which such services are performed.

"Prepaid dental service" specifically includes subscriber contracts issued by dental service associations and dental service corporations as contemplated in Subarticle 3, Article 3, Chapter 71 of Title 38 of the 1976 Code and Insurance Department Regulation 69-34.

(2) Exemption.

The phrase "prepaid dental service" does not include a direct contractual agreement between an individual licensed dentist and an individual patient, under which the individual dentist is personally obligated to perform the dental services specified in the agreement. To qualify for the exemption under the paragraph, the agreement cannot exist between the patient and some third party, such as a marketing firm, a service corporation, or even the dentist's own professional association (P.A.). Instead, the agreement must be exclusively between the individual licensed dentist and the patient, such that the dentist is at all times contractually bound under the agreement to personally provide the promised dental services directly to the patient.

In addition, the phrase "prepaid dental service" shall not include dental benefits provided by a health maintenance organization licensed and regulated under Chapter 33 of Title 38 of the 1976 Code, nor does it include dental benefits provided by a multiple employer self-insured health plan licensed and regulated under Chapter 41 of Title 38 of the 1976 Code.

C. License required.

Every person, firm or entity which offers, sells, delivers or issues for delivery in this State prepaid dental service contracts, as defined in paragraph B above, shall be deemed to be transacting an accident and health insurance business under S. C. Code § 38-1-20(1), shall be deemed to be an insurance company under S. C. Code § 38-1-20(4)(1976), and must be licensed and regulated by the Chief Insurance Commissioner as an insurance company in accordance with S. C. Code §§ 38-5-10 and 38-25-110 (1976). All South Carolina insurance laws and regulations applicable to accident and health insurance companies and accident and health insurance policies shall be fully applicable to prepaid dental service plans and to persons, firms or entities offering, selling, delivering or issuing for delivery such plans in this State.

Editor's Note

This regulation was adopted May 22, 1987.

69–42. Multiple Employer Self–Insured Health Plans.

(Statutory Authority: 1976 Code §§ 38-3-110, 38-41-100, 38-41-110, 1-23-10 **et. seq.** (1976), as amended)

A. Establishment, Maintenance and Control by Employers.

In Public Law 97-473, Congress amended the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 **et. seq.** (ERISA), so as to provide that multiple employer welfare arrangements that are not fully insured are subject to state insurance laws to the extent that such laws are not inconsistent with specific provisions of ERISA. In response to the passage of P.L. 97-473, the South Carolina General Assembly adopted Act No. 137 of 1985, codified as S.C. Code §§ 38-41-10 through 38-41-110 (1976), as amended, (hereinafter "the Act"), to provide a statutory framework by which uninsured or partially insured multiple employer welfare arrangements could be regulated.

Act No. 137 was passed for the benefit and convenience of two or more employers who jointly decide to pool their resources to provide health benefits for their employees. As expressed in §§ 38-41-10 and 38-41-60(a), it was the clear intent of the General Assembly that a multiple employer self-insured health plan be created and maintained by and for the benefit of participating employers and operated under their exclusive management and control. The Act was not intended to permit third party administrators or other entrepreneurial promoters to establish a trust or plan and then proceed to solicit employers as participants. Instead, the impetus for the creation of the plan must come from the employers themselves, and the employers must at all times exercise absolute control over the management and conduct of the plan's business and affairs.

This is not to say that a plan, once established, cannot contract with a third party to provide management or administrative services to the plan. However, any such management or administration agreement must be filed with the Chief Insurance Commissioner at the time that the plan makes application for a license. See, S.C. Code §§ 38-41-30 through 38-41-50 (1976), as amended. The Commissioner will not license any multiple employer self-insured health plan if it appears that it has

not been established and maintained by and for the benefit of participating employers, or that such employers, through their duly elected trustees, exercise anything less than total and absolute control over the plan's business and affairs.

B. Quarterly Reports Required.

Under S. C. Code § 38-41-60(d) (1976), as amended, a multiple employer self-insured health plan is required to file an annual report on its condition and affairs with the Commissioner. Under S.C. Code § 38-41-80 (1976), as amended, a plan is further required to furnish information concerning its business and affairs to the Commissioner or his representatives on demand.

So as to enable the Commissioner to timely monitor the financial condition of multiple employer self-insured health plans, each plan shall, under § 38-41-80, be required to file quarterly reports on its condition and affairs on forms prescribed by the Commissioner. Such reports shall be filed with the Commissioner not later than forty-five (45) days after the close of the calendar quarters ending on March 31, June 30 and September 30. Since the annual report required in § 38-41-80(d) will reflect a plan's condition and affairs at December 31, no separate quarterly report for the quarter ending December 31 shall be required.

C. Hold Harmless Agreements.

Under S. C. Code §§ 38-41-100, 38-41-110 (1976), as amended, the Commissioner is authorized to promulgate regulations to ensure the safe and efficient operation of multiple employer self-insured health plans. One of the most effective ways of doing so is to give the participating employers who, through their elected trustees, establish, maintain and control the plan a direct and ongoing stake or interest in the plan's continued safe and efficient operation.

Therefore, to promote continued safe and efficient operation, a multiple employer self-insured health plan shall require each employer, as a condition of participation in the plan, to execute an agreement by which the employer agrees to personally pay all claims for benefits covered under the plan which are incurred by his or its covered employees and their covered dependents, but which the plan has failed to pay. Such agreements shall be made on forms prescribed by the Commissioner and shall extend to all unpaid claims for benefits incurred by the employer's employees and their dependents during the time such employees and dependents were covered under the plan.

A clear and legible copy of each agreement executed by participating employers shall be filed with the Commissioner by the plan as part of its application for a license. No license will be issued unless copies of such agreements are filed. With respect to an employer who joins the plan after a license has been issued, the plan shall file a copy of the agreement executed by the employer within ten (10) days after the employer joins the plan.

Neither failure of an employer to execute an agreement, nor failure of the plan to require such execution, shall excuse the employer from liability for unpaid claims incurred by covered employees and dependents. An employer shall be deemed to have notice of the requirements of this section, and upon joining the plan, the employer shall be deemed to have agreed to liability for unpaid claims of his covered employees and their dependents in the same manner as if an agreement had been executed.

D. Stop-Loss Coverage Requirements.

The Act requires a multiple employer self-insured health plan to obtain individual and aggregate excess stop-loss coverage from a licensed insurance company. Such coverage must be noncancellable for a minimum term of two years, and it must be submitted for approval by the Commissioner. See, S.C. Code §§ 38-41-30, 38-41-40, 38-41-50 (1976), as amended.

Under §§ 38-41-30, 38-41-40, 38-41-50, plan participants are required to fund benefits up to the point at which the excess stop-loss insurer assumes one hundred percent of the liability to pay benefits. In reviewing an excess stop-loss agreement for approval, the Commissioner will closely scrutinize the agreement to determine whether the levels of individual and aggregate risk retained by the plan are such as will put the plan in an unsound condition or will render its proceedings hazardous to the public or to persons covered under the plan. See, S.C. Code §§ 38-41-100, 38-41-110 (1976), as amended. In making his determination, the Commissioner will consider all relevant factors including, but not limited to, reserving practices, adequacy of employer/employee contributions, benefits provided under the plan, administrative and other expenses, and management. If the Commissioner is of the opinion that the excess stop-loss agreement will put the plan in

an unsound condition, will render the plan's proceedings hazardous to the public or persons covered under the plan, or is otherwise not in compliance with the law, the Commissioner will disapprove the agreement.

HISTORY: Amended by State Register Volume 11, Issue No. 5, eff May 22, 1987.

69–43. Group Health Insurance Coordination of Benefits.

Section 1. Authority.

This regulation is promulgated under S. C. Code §§ 38-3-110(2) and 38-71-720 (1976), as amended.

Section 2. Purpose and Applicability.

A. The purpose of this regulation is to:

(1) Permit, but not require, plans to include a coordination of benefits (COB) provision;

(2) Establish an order in which plans pay their claims;

(3) Provide the authority for the orderly transfer of information needed to pay claims promptly;

(4) Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;

(5) Reduce claims payment delays; and

(6) Make all contracts that contain a COB provision consistent with this regulation.

Section 3. Definitions.

The following words and terms, when used in this regulation, shall have the following meanings unless the context clearly indicates otherwise:

A. Allowable Expenses

(1) "Allowable Expense" means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

(2) Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

(3) When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(4) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

(5) When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

(6) When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(a) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the Primary Plan may be excluded from Allowable Expenses.

(b) This provision shall not be used by a Secondary Plan to refuse to pay benefits because an HMO member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

NOTE: This Paragraph (6) is not intended to allow a Secondary Plan to exclude expenses that are applied towards the satisfaction of the deductible, copayments or coinsurance amounts

required by the Primary Plan, except for the benefit reductions expressly described in this paragraph.

B. Claim

A request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

(1) Services (including supplies);

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of (1) and (2) above; or

(4) An indemnification.

C. Claim Determination Period

This is the period of time, which must not be less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

(1) The Claim Determination Period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

(2) As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

D. Coordination of Benefits

This is a provision establishing an order in which plans pay their claims.

E. Hospital Indemnity Benefits

These are benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

F. Plan

"Plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

(1) The definition shown in the Model COB Provision, attached to this regulation as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

(2) This regulation uses the term "plan." However, a group contract may, instead, use "program" or some other term.

(3) Plan may include:

(a) Group insurance and group subscriber contracts;

(b) Uninsured arrangements of group coverage;

(c) Group coverage through HMOs and other prepayment, group practice and individual practice plans;

(d) The amount by which group hospital indemnity benefits exceed $100 per day;

(e) The medical benefits coverage in group and individual automobile "no fault" and traditional automobile "fault" type contracts; and

(f) Medicare or other governmental benefits, except as provided in (4)(h) below and except as mandated by federal law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) Plan shall not include:

(a) Individual or family insurance contracts;

(b) Individual or family subscriber contracts;

(c) Individual or family coverage through Health Maintenance Organizations (HMOs);

(d) Individual or family coverage under other prepayment, group practice and individual practice plans;

(e) Group hospital indemnity benefits of $100.00 per day or less;

(f) Blanket insurance contracts;

(g) Franchise insurance contracts; and

(h) A State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

G. Primary Plan

A Primary Plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either of the following conditions is true:

(1) The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation. There may be more than one Primary Plan; or

(2) All plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

H. Secondary Plan

A Secondary Plan is a plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other.The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

I. This Plan

In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

Section 4. Model COB Contract Provision.

A. General

Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of B and C below and to the provisions of Section 5.

B. Flexibility

A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

C. Prohibited Coordination and Benefit Design

(1) A group contract may not reduce benefits on the basis that:

(a) Another plan exists;

(b) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(2) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

Section 5. Rules for Coordination of Benefits; Order of Benefits.

A. General

The general order of benefits is as follows:

(1) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in Section 3 Definitions into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(2) A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is Secondary to that other plan.

(3) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

B. Dependent Child/Parents Not Separated or Divorced

The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

(1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

(2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

(3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

(4) If the other plan does not have the rule described in B(1), (2) and (3) above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

C. Dependent Child/Separated or Divorced Parents

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the plan of the parent with custody of the child;

(2) Then, the plan of the spouse of the parent with the custody of the child; and

(3) Finally, the plan of the parent not having custody of the child.

(4) 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. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 5B, Dependent Child/Parents Not Separated or Divorced.

D. Active/Inactive Employee

The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

E. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member o subscriber longer are determined before those of the plan which covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(2) The start of a new plan does not include:

(a) A change in the amount or scope of a plan's benefits;

(b) A change in the entity which pays, provides or administers the plan's benefits; or

(c) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Section 6. Procedure to be followed by Secondary Plan Total Allowable Expenses.

A. When it is determined, pursuant to Section 5, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

B. The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of this COB provision and the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

(1) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

(2) Paragraph B(1) above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 7. Miscellaneous Provisions.

A. Reasonable Cash Values of Services

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

B. Excess and Other Nonconforming Provisions

(1) Some plans have order of benefit determination rules not consistent with this regulation which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation pursuant to Section 2.

(2) A plan with order of benefit determination rules which comply with this regulation (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary"

or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (Noncomplying Plan) on the following basis:

(a) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis;

(b) If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

(c) If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(3) If the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the employee, subscriber or member an amount equal to such difference.

However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

C. Allowable Expense. A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

D. Subrogation. The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

Section 8. Effective Date; Existing Contracts.

A. This regulation is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which shall be ninety (90) days after final publication in the State Register.

B. A group contract which provides health care benefits and was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

(1) The next anniversary date or renewal date of the group contract; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

APPENDIX A. MODEL COB PROVISIONS

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

NOTE: When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph (B)(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, 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. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. [Insurer] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [Insurer] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give [Insurer] any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, [Insurer] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [Insurer] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by [Insurer] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

HISTORY: Added by State Register Volume 14, Issue No. 2, eff February 23, 1990.

69–44. Long Term Care Insurance.

Section 1. Purpose

The purpose of this regulation is to implement S.C. Code Section 38–72–10 et seq., to promote the public interest, to promote the availability of long term care insurance coverage, to protect applicants for long term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long term care insurance coverages, and to facilitate flexibility and innovation in the development of long term care insurance.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Director under S.C. Code Sections 38–72–60 and 38–72–70.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation 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 on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Certain provisions of this regulation apply only to qualified long term care insurance contracts as noted. Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long term care services;

2. The disability income policy is advertised, marketed or offered as insurance for long term care services; or

3. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long term care services.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 4. Definitions

For the purpose of this regulation, the following definitions apply.

A. "Applicant" means:

(1) In the case of an individual long term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long term care insurance policy, the proposed certificate holder.

B. "Certificate" means, for the purpose of this regulation, any certificate issued under a group long term care insurance policy, which policy has been delivered or issued for delivery in this state.

C. "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the insurance department.

D.(1) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified:

(a) Due to changes in laws or regulations applicable to long term care coverage in this state; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Section 20 of this Regulation, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(3) The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(4) The Director, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

E. "Group long term care insurance" means a long term care insurance policy which is delivered or issued for delivery in this State and issued to:

(1) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof of the labor organizations; or

(2) any professional, trade, or occupational association for its members or former or retired members or combination thereof if such association:

(a) is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(b) has been maintained in good faith for purposes other than obtaining insurance; or

(3) an association or to a trust or to the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the department that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the purposes of its members, except for credit unions, the association collects dues or solicits contributions from members, and the

members have voting privileges and representation on the governing board and committees. Ninety days after the filing, the association is considered to have satisfied the organizational requirements unless the director or his designee makes a finding that the association does not satisfy those organizational requirements;

(4) a group other than as described in items (E)(1), (E)(2), and (E)(3), subject to a finding by the director or his designee that the issuance of the group policy is not contrary to the best interest of the public, the issuance of the group policy would result in economies of acquisition or administration, and the benefits are reasonable in relation to the premiums charged.

F. "Incidental," as used in Section 20(J) of this Regulation, means that the value of the long term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

G . "Long-term care insurance" means an insurance policy or a rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, 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. The term includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long term care insurance. It also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term also includes qualified long term care contracts. Long term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or a similar organization to the extent they otherwise are authorized to issue life or health insurance. Long term care insurance does not include an insurance policy offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care. Notwithstanding another provision of this regulation, a product advertised, marketed, or offered as long term care insurance is subject to the provisions of this regulation.

H. "Partnership policies or Partnership program" means those long term care insurance policies that meet the requirements of the Federal Long Term Care Partnership Program as authorized under the Deficit Reduction Act of 2005, Section 6021.

I. "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, or any similar organization.

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

K.(1) "Qualified long term care insurance contract" or "federally tax-qualified long term care insurance contract" means an individual or a group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(a) the only insurance protection provided under the contract is coverage of qualified long term care services. A contract does not fail to satisfy the requirements of this item by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(b) the contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this sub item do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract does not fail to satisfy the

requirements of this subitem by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which payments relate;

(c) the contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subsubitem (e);

(e) all refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund if death occurs of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(f) the contract meets the consumer protection provisions provided in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(2) "Qualified long term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Section 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

L. "Similar policy forms" means all of the long term care insurance policies and certificates issued by an insurer in the same long term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 4E(1) of this Regulation are not considered similar to certificates or policies otherwise issued as long term care insurance, but are similar to other comparable certificates with the same long term care benefit classifications. For purposes of determining similar policy forms, long term care benefit classifications are defined as follows: institutional long term care benefits only, non-institutional long term care benefits only, or comprehensive long term care benefits.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 5. Policy Definitions.

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

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services 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 care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. "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.

I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "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.

L "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "personal care," "home 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 must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 9 of this Regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the other requirements of this Subsection, a qualified long term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B (b)(1)(C) of the Internal Revenue Code of 1986, as amended.

B. Limitations and Exclusions. A policy may 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:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers);

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long term care insurance or health insurance policy;

(7) In the case of a qualified long term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

(8) This Subsection is not intended to prohibit exclusions and limitations by type of provider. However, no long term care issuer may deny a claim because services are provided in a state other than the state of policy issue 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. For purposes of this Subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(9) This Subsection is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of long term care insurance shall be 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. The extension of benefits beyond the period the long term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group long term care insurance issued in this state on or after the effective date of this Section shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this Section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain 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, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this Section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and 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, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this Section, "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers 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.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this Section.

(8) Notwithstanding any other provision of this Section, a converted policy issued to an individual who at the time of conversion is covered by another long term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(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 his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this Section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement.

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

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long term care services.

F. (1) The premium charged to an insured shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 26 of this Regulation, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 26 of this Regulation, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies.

(1) In the case of a group defined in Section 4E(1) of this Regulation, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" pursuant to Sections 501, 505(b), and 507 of the Gramm-Leach-Bliley Act, codified at 15 U.S.C. 6801, 6805(b) and 6807 and Regulation 69–58.

(2) The insurer shall make available, upon request of the Director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 7. Unintentional Lapse

Each insurer offering long term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "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 notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificate holder pays premium for a long term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) of this Section need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1) of this Section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A of this Section, a long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder 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 (5) 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 and certificate.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(2) A long term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

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

C. 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 include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. 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."

E. Other Limitations or Conditions on Eligibility for Benefits. A long term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in S.C. Code Section 38–72–60(D)(2) shall set forth a description of the limitations or conditions, including any

required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. 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.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this Section. If these triggers differ for different benefits, explanation of the trigger 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 shall be specified.

H. A qualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 31(E)(3) of this Regulation that the policy is intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 31(E)(3) of this Regulation that the policy is not intended to be a qualified long term care insurance contract.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This Section shall apply as follows:

(1) Except as provided in Paragraph (2) of this Subsection, this Section applies to any long term care policy or certificate issued in this state on or after 6 months from the effective date of this Regulation.

(2) For certificates issued on or after the effective date of this amended regulation under a group long term care insurance policy as defined in Section 4E(1) of this Regulation which policy was in force at the time this amended regulation became effective, the provisions of this Section shall apply on the policy anniversary following one year from the effective date of this Regulation.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this Subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this Section 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 certificate holder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

(5) (a)Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a long term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this Section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of Subsections B and C of this Section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 10. Initial Filing Requirements

A. This Section applies to any long term care policy issued in this state on or after six months from the effective date of this Regulation.

B. An insurer shall provide the information listed in this Subsection to the Director thirty (30) days prior to making a long term care insurance form available for sale.

(1) A copy of the disclosure documents required in Section 9 of this Regulation; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that 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;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) 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;

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Director may request a demonstration under Subsection C based on a standard age distribution; and

(e)(i) A statement that the premium rate schedule 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

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

C. (1) The Director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(2) In the event the Director asks for additional information under this provision, the period in Subsection B of this Section does not include the period during which the insurer is preparing the requested information.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 11. Prohibition Against Post-Claims Underwriting

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

B. (1)If an application for long term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

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

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, the [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(3) Prior to issuance of a long term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) A report of a physical examination;

(b) An assessment of functional capacity;

(c) An attending physician's statement; or

(d) Copies of medical records.

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

E. Every insurer or other entity selling or issuing long term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance Director in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 12. Minimum Standards for Home Health and Community Care Benefits in Long Term Care Insurance Policies

A. A long term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

B. A long term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 13. Requirement to Offer Inflation Protection

A. No insurer may offer a long term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy 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. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made;

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group as defined in Section 4E(4) of this Regulation to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer in Subsection A in this Section above shall not be required of life insurance policies or riders containing accelerated long term care benefits.

D. (1)Insurers shall include the following information in or with the outline of coverage:

(a) 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 twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

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

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

G. (1) Inflation protection as provided in Subsection A(1) of this Section shall be included in a long term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this Subsection. The rejection may be either in the application or on a separate form.

(2) The rejection shall be considered a part of the 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 have reviewed Plans_____, and I reject inflation protection.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long term care insurance policy or certificate in force or whether a long term care policy or certificate is intended to replace any other accident and sickness or long term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued

to a group as defined in Section 4E(1) of this Regulation, the following questions may be modified only to the extent necessary to elicit information about health or long term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(1) Do you have another long term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long term care insurance policy, a notice regarding replacement of accident and sickness or long term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

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

[Insurance company's name and address]

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

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

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

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

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

_____

(Applicant's Signature)

STATEMENT TO APPLICANT BY AGENT [BROKER 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 the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

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

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance policy delivered herewith 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 accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [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.

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5)

working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies 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 Regulation 69–12.1. 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 long term care replacement requirements.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)

C. 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.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)

F. Every insurer shall report annually by June 30, for qualified long term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E).

G. For purposes of this Section:

(1) "Policy" means only long term care insurance;

(2) Subject to Paragraph (3) in this Subsection, "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;

(3) "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; and

(4) "Report" means on a statewide basis.

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

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 16. Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long term care insurance except as authorized by S.C. Code Section 38–43–10 et seq.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 17. Powers of Director

The Director may, upon written request, waive or grant an exemption to a specific provision or provisions of this regulation with respect to a specific long term care insurance policy or certificate upon a finding that:

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) The modification or suspension is necessary to permit long term care insurance to be sold as part of, or in conjunction with, another insurance product.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 18. Reserve Standards

A. When long term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with S.C. Code Section 38–9–180. Claim reserves shall also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this Subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long term care benefits. However, in no event shall the reserves for the long term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long term care benefit. In the development and calculation of reserves for policies and riders subject to this Subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events;

(2) Covered long term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;

(13) Maximum benefit;

(14) Availability of eligible facilities;

(15) Margins in claim costs;

(16) Optional nature of benefit;

(17) Delay in eligibility for benefit;

(18) Inflation protection provisions; and

(19) Guaranteed insurability option.

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

B. When long term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with Regulation 69–7.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 19. Loss Ratio

A. This Section shall apply to all long term care insurance policies or certificates except those covered under Sections 10 and 20.

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

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification; and

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall 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 considered to provide reasonable benefits in relation to premiums paid, 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 life insurance benefits meets the nonforfeiture requirements of S.C. Code Section 38–63–510 et seq.;

(3) The policy meets the disclosure requirements contained in S.C. Code Section 38–72–10 et seq.;

(4) Any policy illustration that meets the applicable requirements of Regulation 69–40; and

(5) An actuarial memorandum is filed with the insurance department that includes:

(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 must include percent 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 at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a

description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long term care policy provision 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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 20. Premium Rate Schedule Increases

A. This Section shall apply as follows:

(1) Except as provided in Paragraph (2), this Section applies to any long term care policy or certificate issued in this state on or after July 1, 2010.

(2) For certificates issued on or after the effective date of this amended regulation under a group long term care insurance policy as defined in Section 4E(1) of this Regulation, which policy was in force at the time this amended regulation became effective, the provisions of this Section shall apply on the policy anniversary following January 1, 2011.

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Director at least thirty (30) days prior to the notice to the policyholders and shall include:

(1) Information required under Section 9 of this Regulation;

(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 is in compliance with the provisions of this Section;

(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 reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the Director determines as provided in Section 4A(4) of this Regulation that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Director; and

(5) Sufficient information for review and approval of the premium rate schedule increase by the Director.

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

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that 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, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (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 fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (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 Regulation 69–7. 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 review and approval by the Director updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The Director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, 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 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review and approval by the Director every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this Subsection shall be provided to the policyholder in lieu of filing with the Director.

F.(1) If the Director has determined 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 any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable 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 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 condition in Subsection H of this Section; 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 fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).

H.(1) For a rate increase filing that meets the following criteria, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Director 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.

(a) The offer shall:

(i) Be subject to the approval of the Director;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the Director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long term care insurance, the Director may, in addition to the provisions of Subsection H of this Section, prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long term care benefits provided by the policy are incidental, as defined in Section 4B, 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 nonforfeiture requirements as applicable in any of the following:

(a) S.C. Code Section 38–63–510 et seq.;

(b) S.C. Code Section 38–69–210 et seq.; and

(c) Regulation 69–12;

(3) The policy meets the disclosure requirements of S.C. Code Section 38–72–60;

(4) An actuarial memorandum is filed with the insurance department that includes:

(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 must include percent 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 at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) 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.

K. Subsections F and H shall not apply to group insurance policies as defined in Section 4E(1) of this Regulation 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 certificate holders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 21. Filing Requirement

Prior to an insurer or similar organization offering group long term care insurance to a resident of this state pursuant to S.C. Code Section 38–72–50, it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this state.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 22. Filing Requirements for Advertising

A. Every insurer, health care service plan or other entity providing long term care insurance or benefits in this state shall file a copy of any long term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review and approval by the Director to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The Director may exempt from these requirements any advertising form or material when, in the Director's opinion, this requirement may not be reasonably applied.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 23. Standards for Marketing

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

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(b) 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: "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 copies of the disclosure forms required in Section 9C (Appendices B and F) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long term care insurance already has accident and sickness or long term care insurance and the types and amounts of any such insurance, except that in the case of qualified long term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long term care insurance has accident and sickness insurance is not required.

(5) Every insurer or entity marketing long term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Director, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address and telephone number of the program.

(7) For long term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6 A(3) of this Regulation.

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 28D(3), and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 28D(4).

B. In addition to the practices prohibited in Chapter 57 of Title 38, S.C. Code of Laws, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long term care insurance policy.

C.(1) With respect to the obligations set forth in this Subsection, the primary responsibility of an association, as defined in Section 4E(2) of this Regulation, when endorsing or selling long term care insurance shall be to educate its members concerning long term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any long term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in long term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(d) Subparagraphs (a) through (c) shall not apply to qualified long term care insurance contracts.

(7) No group long term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this Subsection.

(8) The insurer shall not issue a long term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this Subsection.

(9) Failure to comply with the filing and certification requirements of this Section constitutes an unfair trade practice in violation of in Chapter 57 of Title 38, S.C. Code of Laws.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 24. Suitability

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

B. Every insurer, health care service plan or other entity marketing long term care insurance (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 agents in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

C.(1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(b) 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

(c) 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.

(2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the "Long Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format

contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Director.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this Section in determining whether issuing long term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

G. 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 similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. 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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 25. 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 to the extent that similar exclusions have been satisfied under the original policy.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 26. Availability of New 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 providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date that the new policy series is made available for sale in this state.

B. Notwithstanding Subsection A above, notification is not required for any policy issued prior to the effective date of this Regulation or to any policyholder or certificate holder 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 that 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 Sections 14 and 24, and the reporting requirements of Section 15A through Section 15E of this Regulation.

F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the offering entity. However, if the policy is issued to a group as defined in Section 4E(4) of this Regulation, the notification shall be made to each certificate holder.

G. Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificate holder. 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 January 1, 2010.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 27. Right to Reduce Coverage and Lower Premiums

A.(1) Every long term care insurance policy and certificate shall include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly or monthly benefit amount.

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

B. The provision required in Section 27(A)(1) of this Regulation shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

C. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

D. The insurer 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.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this Regulation.

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

G. The requirements of this Section shall apply to any long term care policy issued in this state on or after January 1, 2011.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 28. 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 S.C. Code Section 38–72–67:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be 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 S.C. Code Section 38–72–67 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if this offer is accepted for a policy with a fixed or limited premium payment period, the contingent benefit on lapse in Subsection D(4) of this Regulation shall still apply.

D.(1) After rejection of the offer required under S.C. Code Section 38–72–67 for individual and group policies without nonforfeiture benefits issued after the effective date of this Section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to 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%

Issue Age	Percent Increase Over Initial Premium
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 shall also be triggered for policies with a fixed or limited premium paying period every time 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 below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65–80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above 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) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Subsection (6)(c) applies.

(6) On or before the effective date of a substantial premium increase as defined in Subsection D(3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (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. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subsection 28 (D) 6 (b) above if the ratio is forty percent (40%) or more.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection D(3), but not Subsection D(4), are described in this Subsection:

(1) For purposes of this Subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (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 Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes 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. However, the minimum nonforfeiture credit shall not be less than thirty (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)(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 (3) years as well as thereafter.

(b) Notwithstanding Subparagraph (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 will not exceed the maximum benefits which 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 as required under this Section for group and individual policies.

H. The requirements set forth in this Section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraphs (2) and (3) below, the provisions of this Section apply to any long term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this Section, under a group long term care insurance policy as defined in Section 4E(1) of this Regulation, which policy was in force at the time this amended regulation became effective, the provisions of this Section shall not apply.

(3) The last sentence in Subsection C and Subsections D(4) and D(6) shall apply to any long term care insurance policy or certificate issued in this state after July 1, 2010, except new certificates on a group policy as defined in Section 4E(1)of this Regulation after January 1, 2011.

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 Section 19 or Section 20, 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 paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(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 amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Director for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

(a) Reduced paid-up insurance;

(b) Extended term insurance;

(c) Shortened benefit period; or

(d) Other similar offerings approved by the Director.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 29. 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. 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 (3) of the activities of daily living or the presence of cognitive impairment.

B.(1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring;

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. 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, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in this Section shall be effective 12 months after the effective date of this Regulation, and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this Section apply to a long term care policy issued in this state on or after the effective date of the amended regulation.

(2) For certificates issued on or after the effective date of this Section, under a group long term care insurance policy as defined in Section 4E(1) of this Regulation that was in force at the time this amended regulation became effective, the provisions of this Section shall not apply.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 30. Additional Standards for Benefit Triggers for Qualified Long Term Care Insurance Contracts

A. For purposes of this Section the following definitions apply:

(1) "Qualified long term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation 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.

(2)(a) "Chronically ill individual" has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. 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 two (2) activities of daily living for a period of at least ninety (90) days due to a 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" shall 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.

(3) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(4) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

B. A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

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

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

E. Certifications required pursuant to Subsection C may be performed by a licensed health care professional 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 ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day (90) period.

F. Qualified long term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 31. Standard Format Outline of Coverage

This Section of the regulation implements, interprets and makes specific, the provisions of S.C. Code Section 38–72–60 in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

B. The outline of coverage shall contain no material of an advertising nature.

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

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

E. Format for 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, must appear as follows in the outline of coverage.]

Caution: The issuance of this long term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long term care insurance contract under Section 7702B (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 7702B (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 agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

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 deductibles, 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 must be defined and described as part of the outline of coverage.]

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

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(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 should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 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) And finally, 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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 32. Requirement to Deliver Shopper's Guide

A. A long term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Director, shall be provided to all prospective applicants of a long term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under S.C. Code Section 38–72–60.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 33. Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

Section 34. Effective Date

This regulation shall become effective upon publication in the *State Register*.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX A. RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 20[ ]

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

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX B. 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.]

[Note: 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 20%?]

[Note: 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

[Note: 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.

[Note: 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 agent (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: _____

(Agent) (Date)

Agent'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 agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____

(Applicant) (Date)

The company may contact you to verify your answers.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX C. Things You Should Know Before You Buy Long Term Care Insurance

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

[Note: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 to 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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX D. 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.]

[Note: 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.

[Note: 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].

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX E. Claims Denial Reporting Form

Long Term Care Insurance

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. "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.

		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)		

		State Data	Nationwide Data[1]
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.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX F. Long Term Care Insurance

Potential Rate 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:

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've 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%

Issue Age	Percent Increase Over Initial Premium
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Sections 28D(4) and 28D(6) of this Regulation].

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paidup" benefit AND the contingent benefit described above are triggered by the same rate increase, you can chose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65–80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

You bought the policy at age 65 with an annual premium payable for 10 years.

In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

APPENDIX G. 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. Specifically, every insurer shall maintain records for each agent on that agent's amount of long term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

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

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)_____%

HISTORY: Added by State Register Volume 13, Issue No. 6, effective 180 days after June 23, 1989. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010.

69–45. Data Reporting and Determination of Excess Profits.

Section 1. Purpose.

The purpose of this regulation is to provide standards for both the reporting of the loss and expense experience data required by South Carolina Code Section 38-13-300 (1976), as amended, as well as for the determination of the calculation of excess profits required by South Carolina Code Sections 38-73-1100 and 38-73-1110 (1976), as amended.

Section 2. Data Reporting.

South Carolina Code Section 38-13-300 requires that all licensed property or casualty insurers record and report to the Chief Insurance Commissioner, loss and expense experience and any other data which may be necessary to determine that rates are not excessive, inadequate or unfairly discriminatory.

The loss and expense experience report required by this regulation and Section 38-13-300 shall be used, in addition to the supplemental report required by Section 38-13-310, and any other data which

the Commissioner may find necessary, to determine whether an insurer has, pursuant to the provisions of Section 38-73-1100 and Section 38-73-1110, earned an aggregate operating profit in excess of a reasonable amount.

Section 3. Determination of Excess Profits.

(A) Procedure.

If the Commissioner determines that an insurer writing property, casualty, surety, marine, title or allied lines of insurance in South Carolina has earned an aggregate operating profit in excess of either 15% of earned premiums or 25% of the average policyholder surplus over a five-year period, he may:

(1) Order a general reduction in the rates applicable to such line(s) which will reduce the operating profit to a reasonable amount; and

(2) Order a prorata refund of any excessive or unreasonable operating profits, with interest.

HISTORY: Added by State Register Volume 14, Issue No. 3, eff March 23, 1990. Amended by State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

69–46. MEDICARE SUPPLEMENT INSURANCE.

(Statutory Authority: 1976 Code Sections 1–23–110 et seq., 38–3–110, and 38–17–530)

Editor's Note

Unless otherwise noted, the following constitutes the history for 69–46, Section 1 to App. C.

HISTORY: Added by State Register Volume 13, Issue 1, adopted Jan. 27, 1989, eff July 1, 1989. Amended by State Register Volume 14, Issue 6, eff June 22, 1992; State Register Volume 14, Issue 6, eff June 22, 1990; State Register Volume 15, Issue 12, adopted Dec. 27, 1991, eff May 1, 1992; State Register Volume 20, Issue No. 4, eff April 28, 1; State Register Volume 23, Issue No. 3, eff March 26, 1999; State Register Volume 27, Issue No. 10, eff October 24, 2003; State Register Volume 29, Issue No. 7, eff July 22, 2005; State Register Volume 33, Issue No. 5, eff May 22, 2009.

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Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare Supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the director under S.C. Code Sections 38–3–110(2), 38–71–530(b) and 1–23–10 et seq.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 3. Applicability and Scope.

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

(1) All Medicare Supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare Supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 4. Definitions.

For purposes of this regulation:

A. "Applicant" means:

(1) In the case of an individual Medicare Supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group Medicare Supplement policy, the proposed certificateholder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare Supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F. "Creditable coverage"

(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 Title 10 of the United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulations; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) "Creditable coverage" shall not include one or more, or any combination of, 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 on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare Supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 Title 10 of the United States Code; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare Supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w–28(b)(1), and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of- service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

L. "Medicare Supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Pre-Standardized Medicare Supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare Supplement insurance issued prior to May 1, 1992.

N. "1990 Standardized Medicare Supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare Supplement insurance issued on or after May 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare Supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

O. "2010 Standardized Medicare Supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare Supplement insurance issued with an effective date for coverage on or after June 1, 2010.

P. "Policy" means the form on which the policy is delivered or issued for delivery by the issuer.

Q. "Secretary" means the Secretary of the United States Department of Health and Human Services.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 5. Policy Definitions and Terms.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89–97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 6. Policy Provisions.

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8. 1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare Supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare Supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D.(1) Subject to Sections 7A(4), (5) and (7), and 8A(4) and (5), of this regulation, a Medicare Supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare Supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare Supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to May 1, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare Supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the director of this state, an issuer shall neither cancel nor nonrenew a Medicare Supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare Supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificateholders an individual Medicare Supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) An individual Medicare Supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare Supplement policy; and

(ii) An individual Medicare Supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificateholder the conversion opportunities described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(d) If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage

under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare Supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After May 1, 1992 and With an Effective Date for Coverage Prior to June 1, 2010.

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 1992 and with an effective date for coverage prior to 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.

A. General Standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the

applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare Supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificateholders an individual Medicare Supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificateholder in a group Medicare Supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in Section 8A(5)(c); or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare Supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare Supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(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 certificateholder 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 ninety (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.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare Supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 9 of this regulation) to a 2010 Standardized plan (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director.

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare Supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare Supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9)(a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

(ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

D. Standards for Plans K and L.

(1) Standardized Medicare Supplement benefit plan "K" shall consist of the following:

(a) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of- pocket limitation is met as described in Subparagraph (j);

(g) Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) below;

(i) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare Supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j), but substituting $2000 for $4000.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 8.1. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage 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 the effective date of these 2010 Standardized Medicare Supplement benefit plan standards in this state. Benefit standards applicable to Medicare Supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 8 of this regulation.

A. General Standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare Supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificate-holders an individual Medicare Supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this Subsection.

(d) If an individual is a certificateholder in a group Medicare Supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare Supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare Supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(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 certificateholder 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 ninety (90) days after the date of the loss.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare Supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a

calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After May 1, 1992 and With an Effective Date for Coverage Prior to June 1, 2010.

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Standardized Medicare Supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare Supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare Supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare Supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare Supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare Supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare Supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible

shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare Supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare Supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(10) Standardized Medicare Supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(11) Standardized Medicare Supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(12) Standardized Medicare Supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

F. Make-up of two Medicare Supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare Supplement benefit plan "K" shall consist of only those benefits described in Section 8D(1).

(2) Standardized Medicare Supplement benefit plan "L" shall consist of only those benefits described in Section 8D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare Supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of

simplification of Medicare Supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 9.1. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage 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 with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 9 of this regulation.

A.(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare Supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare Supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare Supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare Supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare Supplement regular Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and

medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare Supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare Supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2A(4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare Supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of- pocket limitation is met as described in Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j);

(i) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare Supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare Supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare Supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with copayments in the following amounts:

(a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare Supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare Supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 9.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020.

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 S.C. Code Section 38–71–10 et. seq. and Section 9.1 of this Regulation.

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply 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, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1E(3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1E(5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1E(6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(5) The reference to Plans C or F contained in Section 9.1A(2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) By reason of attaining age 65 on or after January 1, 2020; or

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act (''waivered'' alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4) above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Section 9.1E of this regulation.

HISTORY: Added by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 10. Medicare Select Policies and Certificates.

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) ''Complaint'' means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) ''Grievance'' means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) ''Medicare Select issuer'' means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) ''Medicare Select policy'' or ''Medicare Select certificate'' mean respectively a Medicare Supplement policy or certificate that contains restricted network provisions.

(5) ''Network provider'' means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) ''Restricted network provision'' means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) ''Service area'' means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

C. The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

E. A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to Supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the director.

F. (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare Supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare Supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 11. Open Enrollment.

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare Supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B.(1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 12. Guaranteed Issue for Eligible Persons.

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare Supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare Supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare Supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare Supplement policy.

B. Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated;

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3)(a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

(4) The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because:

(a)(i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

(b) The issuer of the policy substantially violated a material provision of the policy; or

(c) The issuer, or a producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5)(a) The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all Supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare Supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods.

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled. The Medicare Supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare Supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

(2)(a) Subject to Subparagraph (b), Section 12B(5) is the same Medicare Supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare Supplement policy with an outpatient prescription drug benefit, a Medicare Supplement policy described in this subparagraph is:

(i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Section 12B(6) shall include any Medicare Supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare Supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare Supplement policy with outpatient prescription drug coverage.

F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Section

12A. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 13. Standards for Claims Payment.

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100–203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare Supplement insurance experience reporting form.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 14. Loss Ratio Standards and Refund or Credit of Premium.

A. Loss Ratio Standards.

(1)(a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire

future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(4) For policies issued prior to May 1, 1992, expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with July 22, 2005 to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare Supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare Supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare Supplement policies and certificates issued before or after the effective date of May 1, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare Supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare Supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare Supplement policies or certificates. No premium adjustment which would modify the

loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare Supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare Supplement benefits provided by the policy or certificate.

D. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this regulation if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 15. Filing and Approval of Policies and Certificates and Premium Rates.

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare Supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

D.(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare Supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare Supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

E.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare Supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare Supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare Supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 14, subsection B.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

G. An issuer shall not present for filing for approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 16. Permitted Compensation Arrangements.

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare Supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 17. Required Disclosure Provisions.

A. General Rules.

(1) Medicare Supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare Supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare Supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum

standards for Medicare Supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare Supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare Supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare Supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare Supplement insurance policies or certificates in a format acceptable to the director. The notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare Supplement policy or certificate; and

(b) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

☐Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

☐Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

☐Blood - First three pints of blood each year.

☐Hospice - Part A coinsurance.

A	B	C	D	F F *	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B coinsurance *	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2200] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible

		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[5120]; paid at 100% after limit reached	Out-of-pocket limit $[2560]; paid at 100% after limit reached		

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded. [Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plan may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: An "√" means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants	Medicare first eligi-

	A	B	D	G [1]	K	L	M	N	C	F [1]
									ble before 2020	only
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurance or Copayment	√	√	√	√	50%	75%	√	√ co-pays ap-ply [3]	√	√
Blood (first three pints)	√	√	√	√	50%	75%	√	√	√	√
Part A hospice care coinsurance or copayment	√	√	√	√	50%	75%	√	√	√	√
Skilled nursing facility coinsurance			√	√	50%	75%	√	√	√	√
Medicare Part A deductible		√	√	√	50%	75%	50%	√	√	√
Medicare Part B deductible									√	√
Medicare Part B excess charges				√						√
Foreign travel emergency (up to plan limits)			√	√			√	√	√	√
Out-of-pocket limit in [2017] [2]					[$5120] [2]	[$2560] [2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of [$2200] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
[3] Plan N pays 100% of the Part B coinsurance, except for co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$0	$[1316](Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hos-			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
pital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	$0	Up to $[164.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0

- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316](Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	$0	Up to $[164.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPA-			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
TIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316](Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0

Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day $0	$0
- Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from

billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183](Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[658] a day	$[658] a day	$0
Once lifetime reserve days Are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0 ***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare Copayment/coinsurance	$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket

expenses are [$2200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**]	PLAN PAYS [IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare			
Approved Amounts*	$0 $[183] (Part B deductible)	$0	
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of			
Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
- First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs	Medicare copayment/coinsurance	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE, **] YOU PAY
	and inpatient respite care		

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $2200] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,]** YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $2200] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,]** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[5120] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called ''Excess Charges'') and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[658](50% of Part A deductible)	$[658](50% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 ***
- Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[154.50] a day	Up to $[82.25] a day (50% of Part A Coinsurance)	Up to $[82.25]a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited		
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	copayment/coinsurance for out-patient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coin surance ♦

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**** Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$5120]) *
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[5120] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts *****	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10% ♦

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[987] (75% of Part A deductible)	$[329] (25% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$[329] (25% of Part A deductible) ♦
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 ***
- Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[123.38] a day (75% of Part A Coinsurance)	Up to $[41.13] a day (25% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦
You must meet Medicare's requirement, including a doctor's certification of terminal illness.			

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**** Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2560]) *
BLOOD			
First 3 pints	$0	75%	25% ♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2560] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts *****	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[658] (50% of Part A deductible)	$[658] (50% of Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirement, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirement, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**** Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance other than up to [$20] per office visit and up to [$50] per emergency room visit The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare Supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 18. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare Supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A Supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare Supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your

Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1)(a) Did you turn age 65 in the last 6 months?

Yes ___ No ___

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes ___ No ___

(c) If yes, what is the effective date? ___

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes ___ No ___

If yes,

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?

Yes ___ No ___

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes ___ No ___

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

Yes ___ No ___

(c) Was this your first time in this type of Medicare plan?

Yes ___ No ___

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes ___ No ___

(4)(a) Do you have another Medicare Supplement policy in force?

Yes ___ No ___

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?

Yes ___ No ___

(5) Have you had coverage under any other health insurance within the past 63 days?

(For example, an employer, union, or individual plan)

Yes ___ No ___

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START ___/___/___ END ___/___/___

(If you are still covered under the other policy, leave "END" blank.)

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. In the case of a direct response issuer, a copy of the application or Supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare Supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare Supplement policy or certificate, a notice regarding replacement of Medicare Supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare Supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

___ Additional benefits.

___ No change in benefits, but lower premiums.

___ Fewer benefits and lower premiums.

___ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

___ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

___ Other. (please specify) _____

1. Note: If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for 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, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, 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 still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) *

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

* Signature not required for direct response sales.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 19. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare Supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review or approval by the Director to the extent it may be required under state law.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare Supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in S.C. Code Sections 38–57–10 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 an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare Supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare Supplement policy or certificate that will provide an individual more than one Medicare Supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare Supplement policy or certificate:

(1) Policy and certificate number; and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare Supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. An issuer of a Medicare Supplement policy or certificate;

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and

2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. An issuer of a Medicare Supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C shall not be construed to preclude an issuer of a Medicare Supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D, an issuer of a Medicare Supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare Supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.

G. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare Supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare Supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this Section only:

(1) ''Issuer of a Medicare Supplement policy or certificate'' includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) ''Family member'' means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) ''Genetic information'' means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term ''genetic information'' does not include information about the sex or age of any individual.

(4) ''Genetic services'' means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) ''Genetic test'' means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term ''genetic test'' does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) ''Underwriting purposes'' means:

(a) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) the computation of premium or contribution amounts under the policy;

(c) the application of any preexisting condition exclusion under the policy; and

(d) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 25. Severability

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

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

Section 26. Effective Date

This regulation shall be effective upon publication in the State Register.

HISTORY: Amended by SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

App. A. MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR	
TYPE [1]	SMSBP [2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Conducting Exhibit
Title	Telephone Number

Line	(a) Earned Premium [3]	(b) Incurred Claims [4]
1. Current Years' Experience		
a. Total (all policy years)		
b. Current year's issues [5]		
c. Net (for reporting purposes = 1a–1b		
2. Past Years' Experience (all policy years)		
3. Total Experience (Net Current Year + Past Year)		
4. Refunds Last Year (Excluding Interest)		
5. Previous Since Inception (Excluding Interest)		
6. Refunds Since Inception (Excluding Interest)		
7. Benchmark Ratio Since Inception *(see worksheet for Ratio 1)*		
8. Experienced Ratio Since Inception (Ratio 2)		
Total Actual Incurred Claims (line 3, col. b) / Total Earned Prem. (line 3, col. a)-Refunds Since Inception (line 6)		
9. Life Years Exposed Since Inception		
If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10. Tolerance Permitted (obtained from credibility table)		

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3] Includes Modal Loadings and Fees Charged.
[4] Excludes Active Life Reserves.
[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios".

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000+	0.0%
5,000 — 9,999	5.0%
2,500 — 4,999	7.5%
1,000 — 2,499	10.0%
500 — 999	15.0%
If less than 500, no credibility	

11. Adjustment to Incurred Claims for Credibility	
Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims	
[Total Earned Premiums (line 3, col. a)-Refunds Since Inception (line 6)] × Ratio 3 (line 11)	

13. Refund = Total Earned Premiums (line 3, col. a)-Refunds Since Inception (line 6) -[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____

Signature

_____

Name - Please Type

_____

Title - Please Type

_____

Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES

FOR CALENDAR YEAR	
TYPE [1]	SMSBP [2]
For the State of	Company Name
NAIC Group Code NAIC	Company Code
Address	Person Conducting Exhibit
Title	Telephone Number

(a)[3] Year	(b)[4] Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o)[5] Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ [6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(*l*):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK

RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES

FOR CALENDAR YEAR_____

TYPE[1]	SMSBP[2]
For the State of	
Company Name	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Conducting Exhibit
Title	Telephone Number

(a)**3** Year	(b)**4** Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(*o*)**5** Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+**6**		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(*l*):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
3 Year 1 is the current calendar year — 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

HISTORY: Added by State Register Volume 13, Issue 1, adopted Jan. 27, 1989, eff July 1, 1989. Amended by State Register Volume 14, Issue 6, eff June 22, 1992; State Register Volume 14, Issue 6, eff June 22, 1990; State Register Volume 15, Issue 12, adopted Dec. 27, 1991, eff May 1, 1992; State Register Volume 20, Issue No. 4, eff April 28, 1; State Register Volume 23, Issue No. 3, eff March 26, 1999; State Register Volume 27, Issue No. 10, eff October 24, 2003; State Register Volume 29, Issue No. 7, eff July 22, 2005; State Register Volume 33, Issue No. 5, eff May 22, 2009; SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

APPENDIX B. FORM FOR REPORTING

MEDICARE SUPPLEMENT POLICIES

Company Name:_____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

HISTORY: Added by State Register Volume 13, Issue 1, adopted Jan. 27, 1989, eff July 1, 1989. Amended by State Register Volume 14, Issue 6, eff June 22, 1992; State Register Volume 14, Issue 6, eff June 22, 1990; State Register Volume 15, Issue 12, adopted Dec. 27, 1991, eff May 1, 1992; State Register Volume 20, Issue No. 4, eff April 28, 1; State Register Volume 23, Issue No. 3, eff March 26, 1999; State Register Volume 27, Issue No. 10, eff October 24, 2003; State Register Volume 29, Issue No. 7, eff July 22, 2005; State Register Volume 33, Issue No. 5, eff May 22, 2009; SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

APPENDIX C. DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously. [Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

□hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

□any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

☐hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐hospice

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐hospice

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

□any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□hospice

□other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

□any expenses or services covered by the policy are also covered by Medicare; or

□it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□hospice care

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items & services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

☐the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐hospice

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□hospice

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□hospice

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

□hospitalization

□physician services

□hospice

□[outpatient prescription drugs if you are enrolled in Medicare Part D]

□other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐hospice care

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐hospitalization

☐physician services

☐hospice

☐[outpatient prescription drugs if you are enrolled in Medicare Part D]

☐other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

HISTORY: Added by State Register Volume 13, Issue 1, adopted Jan. 27, 1989, eff July 1, 1989. Amended by State Register Volume 14, Issue 6, eff June 22, 1992; State Register Volume 14, Issue 6, eff June 22, 1990; State Register Volume 15, Issue 12, adopted Dec. 27, 1991, eff May 1, 1992; State Register Volume 20, Issue

No. 4, eff April 28, 1; State Register Volume 23, Issue No. 3, eff March 26, 1999; State Register Volume 27, Issue No. 10, eff October 24, 2003; State Register Volume 29, Issue No. 7, eff July 22, 2005; State Register Volume 33, Issue No. 5, eff May 22, 2009; SCSR 42–1 Doc. No. 4804, eff January 26, 2018.

69–47. Private Review Agents.

(Statutory Authority: 1976 Code §§ 38–70–60, 1–23–10 et seq., and Acts 311 of 1990)

I. Purpose.

The purpose of this regulation is to implement and enforce the provisions and statutory requirements contained in Act 311 of 1990 and to establish applicable fees and standards for private review agents operating in South Carolina.

II. Definitions.

For the purposes of this regulation, the following terms are defined as:

A. "Appeal"—A request to reconsider a determination not to certify an admission, procedure, extension of stay or other health care service.

B. "Certificate"—Renewable certificate of registration granted by the Commissioner to a private review agent, authorizing the private review agent to perform utilization reviews in this State for two years. This certificate is not transferable.

C. "Certification"—A determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care or effectiveness under the applicable health benefit plan.

D. "Commissioner"—The Chief Insurance Commissioner of South Carolina.

E. "Discharge Planning"—The process of assessing a patient's need for treatment after hospitalization to facilitate the necessary services and resources for an appropriate and timely discharge.

F. "Health Care Provider"—Any attending health care provider, facility or practitioner, authorized under state or federal law to bill for health care services rendered.

G. "Other Party Designated"—Any person or entity designated by the insured to receive notice of certification or denials thereof. This term shall presumptively include the primary attending health care provider and any other affected health care provider of record.

H. "Private Review Agent"—A corporation, partnership, association or any other entity performing utilization reviews. All private review agents not hereinafter exempt must obtain a certificate.

1. The State of South Carolina or any South Carolina business entity which uses its employees to perform utilization reviews on behalf of its employees or any hospital which performs utilization reviews is not required to obtain a certificate, unless the hospital is performing those reviews for a fee for an entity which is not owned or affiliated with the hospital.

2. Insurance companies, administrators of insurance benefit plans and health maintenance organizations licensed and regulated by the Department which perform utilization reviews are not required to obtain a certificate. However, each of these entities must comply with Sections IV through XI of this regulation.

3. Private review agents performing utilization reviews only for single-employer, self-insured employee health benefit plans are not required to obtain a certificate.

4. Private review agents performing utilization reviews only for health care services provided pursuant to a federal law, which specifically preempts state regulation, are not required to obtain a certificate.

I. "Utilization Criteria"—The written policies, rules, medical protocols, or guides used by the private review agent to review, grant or deny certification.

J. "Utilization Review"—A system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.

III. Certificate of Registration/Application Fee/Annual Registration Fee.

A. Before performing utilization reviews on residents of this State, all private review agents not exempted by Section II.G. of this regulation must obtain a certificate using the application provided by the Commissioner. The application fee is $400.00. Any significant change in utilization review criteria, program design, or service delivery must be updated annually by not later than July 1. Every private review agent must pay a biennial certificate fee of $800.00 by not later than July 1. If the private review agent's certificate lapses for nonpayment of the biennial certificate fee or if the certificate is terminated for any reason, then the private review agent must refile the application along with the $400.00 application fee. Certificates will be renewed by the Commissioner biennially on July 1 of even-numbered years.

B. The source of each private review agent's utilization criteria must be reflected on the application for a certificate. Utilization criteria must be periodically reviewed and revised as appropriate. Any significant change in the source of a private review agent's utilization criteria must be disclosed annually by no later than July 1.

IV. Procedures for Utilization Review Determinations.

A. Private review agents must have written procedures to assure that utilization reviews are conducted in a timely manner.

1. Private review agents must make a certification determination within two working days of receipt of the necessary information. Private review agents must make a certification determination of an extended stay or additional service within one working day of receipt of the additional information. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review. Regardless, a certification determination must be made within thirty days of receipt of the request.

2. Private review agents may review ongoing inpatient stays, but must not routinely conduct daily review on all such stays. The frequency of such reviews should vary based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity.

3. Private review agents must establish a reasonable target review period for each admission. Except for contractually required case management activities related to discharge planning programs, private review agents may not contact a hospitalized patient until the final day of the target period.

B. Private review agents must have in place written procedures for providing notification of their determinations in accordance with the following:

1. When a determination is made to issue a certification, notification must be provided immediately either by telephone or by telecopier facsimile transmission machine to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. Notification of the certification must thereafter be transmitted in writing to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated within two working days of the determination or request. The certification must include the certified length of stay and the date of the next review. A written confirmation of certification of an extended stay or additional service must include the number of extended days, the next review date, the new total number of days approved and the date of admission. All notifications of certification must include the following or similar language: "This certification does not guarantee payment of benefits under your insurance policy. That determination can only be made by your insurer under the terms of your insurance policy."

2. When a determination is made to deny certification, notification must be provided immediately either by telephone or by telecopier facsimile transmission machine to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. Notification of the denial of certification must be transmitted in writing to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated within one

working day of the determination or request. The written notification must include the principal reason(s) for the denial of certification and the procedure for appealing the denial of certification.

V. Appeals Process.

A. Private review agents must have procedures for appeals of denials of certification. The right to appeal must be available to the the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. The right to appeal must include the right to request that the health care provider performing the review must practice the same profession as the attending health care provider and the right to request that the review be performed by a health care provider who did not make the initial denial of certification. The appeal procedure may require that an appeal be filed within a specified period from the denial of certification. In no event may this period be less than sixty days from the denial of certification.

1. Standard Appeal.

a. Private review agents must establish procedures for appeals to be made both in writing and by telephone.

b. Private review agents must notify in writing the person or entity who initiated the request, or the patient, enrollee, insured or other party designated of its determination on an appeal, as soon as practical, but in no case later than thirty days after receiving all information necessary to complete the appeal. If the appeal is denied, the notification must contain justification for the denial. In extraordinary circumstances, the thirty-day period to determine appeals may be extended for not more than sixty days. Private review agents must maintain records documenting the necessity for extending standard appeal determinations, which must be made available to the Commissioner on demand.

2. Expedited Appeal.

When a determination to deny certification is made and the person or entity who initiated the request, or the patient, enrollee, insured or or other party designated believes that the determination warrants immediate appeal, an opportunity to appeal that determination over the telephone on an expedited basis must be afforded. A decision on an expedited appeal must be communicated to the appellant by telephone within two working days of receipt of all information necessary to complete the appeal. Private review agents must have written procedures to assure reasonable access to their consulting health care providers for such appeals. Expedited appeals which do not resolve a difference of opinion may, at the option of the appellant, be resubmitted through the standard appeal process.

VI. Information Upon Which Utilization Review Is Conducted.

A. When conducting utilization reviews, private review agents must collect only the information necessary to issue a certification.

B. Private review agents must not require health care providers to supply numerically codified diagnoses or procedures as a condition for certification. Private review agents may request such coding, since its inclusion may expedite utilization reviews.

C. Private review agents must not require copies of medical records on all utilization reviews as a matter of routine. Copies of pertinent medical records may be required when a difficulty develops in certification or for retrospective review.

VII. Retrospective Review.

Private review agents may conduct retrospective reviews of certifications only for purposes of internal quality assurance, procedural compliance with the terms of the health benefit plan and auditing of the appropriateness of health care services certified and provided. Once certification is issued by a private review agent, then except for fraud committed by patient, enrollee, insured, or health care provider, retrospective review of that certification must not result in any additional cost to an innocent patient, enrollee, insured, or health care provider. Except as provided above, any errors in certification must be resolved between the private review agent and the third-party payer.

VIII. Accessibility.

A. Private review agents must conduct utilization reviews and provide access to their utilization review staff by a toll-free line at a minimum of forty hours per week, during normal business hours, in the health care provider's local time zone, unless otherwise mutually agreed.

B. Private review agents must provide sufficient telephone lines to ensure a reasonable response time to inquiries. A reasonable response time is a telephonic queue time not exceeding ninety seconds.

C. Private review agents conducting on-site utilization reviews must verify their identity to the health care provider and comply with health care provider protocols and administrative procedures to minimize disruption of patient care or operations of the health care provider.

D. Private review agents not exempted by Section II.G. must provide their South Carolina certificate number upon request.

IX. Staff and Program Qualifications.

A. Staff Qualifications.

1. Private review agents must have adequate utilization review staff who are properly trained, qualified, and supervised by appropriate health care providers, and supported by utilization criteria.

2. Health care providers conducting utilization reviews must be licensed as health care providers by an approved state licensing agency in the United States.

B. Program Qualifications.

1. Utilization criteria must be established under the direct supervision of a health care provider licensed in the same profession and practicing in the same or a similar specialty as typically manages the medical condition, procedure or treatment. A summary description of the utilization criteria must be provided to the Commissioner on demand.

2. Private review agents must develop and use an internal ongoing written quality assessment program. This written program must be made available to the Commissioner on demand.

3. Private review agents must maintain materials informing insureds or enrollees of the requirements for certification. Those materials must include an overview of the rights and responsibilities of insureds and enrollees, the telephone number and address of the private review agent and a description of the appeals process. The private review agent must either directly distribute these materials to the insured or enrollee or provide them to the insurer or payer for distribution.

X. Confidentiality.

A. Private review agents must have written procedures for assuring that patient-specific information obtained during utilization reviews will be:

1. Kept confidential in accordance with applicable federal and state laws; and

2. Used solely for the purposes of utilization reviews, internal quality assurance, discharge planning, case management or claims payment.

B. Patient-specific information must be disclosed to the Commissioner on demand, subject to an appropriate proprietary agreement to ensure confidentiality.

C. Statistical data which does not provide sufficient information to allow identification of individual patients is not considered confidential for purposes of this regulation.

XI. Effective Date.

This regulation shall become effective ninety days after final publication in the *State Register*.

HISTORY: Added by State Register Volume 19, Issue No. 5, eff May 26, 1995.

69–48. Life And Health Reinsurance Agreements.

(Statutory Authority: 1976 Code §§ 38–3–110(1), 38–9–170(1)(b), 38–9–190, and 1–23–10 et seq.)

Section I. Preamble.

A. The South Carolina Department of Insurance recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

B. However, it is improper for a licensed insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in

the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival. The terms of such agreements referred to herein and described in Section III violate:

1. Statutory provisions relating to financial statements which do not properly reflect the financial condition of the ceding insurer;

2. Statutory provisions relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and

3. Statutory provisions relating to creating a situation that may be hazardous to policyholders and the people of this State.

Section II. Scope.

This regulation shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar regulation in their domiciliary state. This regulation shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This regulation shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

Section III. Accounting Requirements.

A. No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

1. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer 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). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured;

2. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

3. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

4. The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

5. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

6. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of

business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk Categories:

a. Morbidity.

b. Mortality.

c. Lapse.

This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

d. Credit Quality (C1).

This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

e. Reinvestment (C3).

This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

f. Disintermediation (C3).

This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

RISK CATEGORY	a	b	c	d	e	f
Health Insurance - Other than LTC/LTD*	+	0	+	0	0	0
Health Insurance - LTC/LTD*	+	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	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	0	+	+	+	+	+

* LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance

7.a. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not [other than for the classes of business excepted in Paragraph (7)(b)] either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the Commissioner which legally segregates, by contract or contract provision, the underlying assets.

b. Notwithstanding the requirements of Paragraph (7)(a), the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

—Health Insurance - LTC/LTD

—Traditional Non-Par Permanent
—Traditional Par Permanent
—Adjustable Premium Permanent
—Indeterminate Premium Permanent
—Universal Life Fixed Premium
(no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2(I + CG)}{X + Y - I = CG}$$

Where: I is the net investment income (Exhibit 2, Line 16, Column 7)

CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6)

X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1)

Y is the same as X but for the prior year

8. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date.

9. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

10. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

11. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

B. Notwithstanding Subsection A, an insurer subject to this regulation may, with the prior approval of the Commissioner, take such reserve credit or establish such asset as the Commissioner may deem consistent with the South Carolina Code of Laws, Rules or Regulations, including actuarial interpretations or standards adopted by the Department.

C.1. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within thirty (30) days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this Department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

2. Any increase in surplus net of federal income tax resulting from arrangements described in Subsection C(1) shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

[For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20

million — $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

At the end of year N + 1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million [66% of ($4 million — $1 million — $.5 million) up to a maximum of $13.2 million] on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and —$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.]

Section IV. Written Agreements.

A. No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

B. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

C. The reinsurance agreement shall contain provisions which provide that:

1. The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

2. Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

Section V. Existing Agreements.

Insurers subject to this regulation shall reduce to zero by December 31, 1993, any reserve credits or assets established wit respect to reinsurance agreements entered into prior to the effective date of this regulation which, under the provisions of this regulation would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

Section VI. Effective Date.

This regulation shall become effective upon final publication in the State Register.

HISTORY: Added by State Register Volume 15, Issue No. 4, eff April 26, 1991. Amended by State Register Volume 18, Issue No. 3, eff March 25, 1994.

69–50. Continuing Insurance Education.

I. Purpose

The purpose of this regulation is to establish rules and standards which shall apply to continuing insurance education for individuals qualified or licensed to act as insurance producers in this State.

II. Scope

A. The rules contained in this regulation shall apply to all individuals qualified or licensed to act as insurance producers in this State, except:

1. Limited line insurance producers;

2. Limited line credit insurance producers; and

3. Nonresident producers who have successfully satisfied continuing insurance education requirements of their resident state, regardless of the requirements of that other state.

B. Multi-line producers who do not wish to complete the required eight hours in each line of authority held must submit a request in writing to the Department to cancel the line(s) of authority in which they do not wish to complete the eight required hours. However, the producer must

complete a total of twenty-four hours of continuing education with at least three hours in courses approved as ethics.

C. The Director of Insurance at his discretion may mandate certain continuing education courses to be taken by producers to meet continuing education compliance.

III. Definitions

When used with these regulations, the following definitions apply:

(1) "Approved Course" is a course offered in a classroom environment that is approved by the South Carolina Department of Insurance for continuing insurance education credit. Approved courses may include information on specific insurance products approved for sale in the state, relevant state or national laws, taxation related to insurance, insurance practices, ethics, claim procedures and policyholder relations. Approved courses shall not include courses or portions of courses developed for prelicensing education, for personal development, motivation, sales, or personal enrichment. Approved courses must be led or monitored by an approved instructor.

(2) "Approved Instructor" means an individual who has been approved by the Department of Insurance in accordance with Section VI of this Regulation and who teaches or otherwise instructs an approved continuing education course. The individual must have competency in the subject matter of the course.

(3) "Proctor" means a disinterested third party.

(4) "Approved Sponsor" is a responsible organization which demonstrates it is capable of offering, conducting, and maintaining quality controls of courses. Approved sponsors may include licensed insurance companies, producer associations, insurance trade associations, private organizations, and institutions of higher learning. A sponsor must be approved by the Department.

(5) "Classroom" is a location conducive to learning, and may include a traditional classroom, an auditorium, or other meeting-place, which provides an environment suitable for the transfer of information.

(6) "Classroom Hour" is at least fifty minutes of participation in an approved course in a classroom, teleconference or distance learning. Not more than ten minutes of any sixty-minute period may be used for breaks, roll taking, or administrative instructions.

(7) "Competency Examination" is a closed book examination taken and passed by the producer without assistance and personally monitored by a proctor who is not related to the producer, is not his immediate supervisor, or his employee. A score of 70 or above is required for the examinee to pass the examination.

(8) "Compliance Deadline" means every two years by 5 P.M. on the last day of the licensee's month of birth. Individuals born in an even numbered year must comply every even numbered year by the last day of the individual's month of birth. Individuals born in an odd numbered year must comply every odd numbered year by the last day of the individual's month of birth.

(9) "Compliance With Continuing Education for Resident Producers" means completing twenty-four hours of continuing education by the compliance deadline, with a minimum of eight hours in each line of authority, with at least three hours of ethics and paying a recordkeeping fee to the Continuing Education Administrator by the compliance deadline in a biennial compliance year.

(10) "Compliance With Continuing Education for Nonresident Producers" means meeting the continuing education requirements in their home state.

(11) "Continuing Education Administrator" means the Continuing Education Administrator responsible for administering the continuing insurance education requirements. The Director may designate a Continuing Education Administrator within the Department or, in the alternative, contract with an outside service provider to function as continuing education administrator and to provide record-keeping services.

(12) "Course" means an organized, outlined body of information intended to convey knowledge or information to the producer.

(13) "Credit Hour" is a value assigned to an approved course by the Department. Hours of credit are calculated in full hours.

(14) "Department" means the South Carolina Department of Insurance.

(15) "Director" means the Director of the Department of Insurance or his designee.

(16) "Product-Specific" or "Specific Insurance Products" means information about a particular policy, procedure, or coverage. This includes, but is not limited to, special rating information, special underwriting practices, and specialized or unique claim procedures of a company or group of companies.

(17) "Recordkeeping Fee" means the fee paid to the Continuing Education Administrator to cover the costs of compiling and maintaining records reflecting the continuing insurance education status of all licensed or qualified producers.

(18) "Self-study Hour" is a study period of fifty minutes from an approved course followed by a competency examination. Self-study hours may include textbook study, video study, intranet, internet, CDROM and other electronic means of information communication.

IV. Sponsor Approval

A. Sponsors must be approved by the Department of Insurance before they may submit courses for approval to the Department. The application to become a sponsor must be submitted to the Department at least thirty (30) days prior to the Continuing Education Advisory Committee meeting. If the applicant's type of business is a private entity, other than an insurance company, producer's trade association, institution of producer's trade association or institution of higher learning, the applicant must submit a letter explaining the applicant's type of business and how long the business has been offering insurance education courses.

B. Before an approved sponsor may offer any course, the sponsor must submit the course to the Department for approval and be assigned a course approval number by the Department.

C. Sponsors may not use another sponsor's course approval number without the prior written authorization of the sponsor. A copy of the authorization must be submitted to the Department before the course may be offered.

D. Approved sponsors of approved courses are responsible for collecting accurate attendance records and maintaining records containing the names of producers who completed all sessions of the approved course, or who successfully completed the competency examination for courses approved for self-study. Sponsors shall maintain these records for a three-year period following the date of approved course completion. These records must be made available to the Department upon request.

E. Approved sponsors are responsible for the actions of their instructors.

F. Approved sponsors may only offer courses which have been approved by the Department.

G. Approved sponsors must notify the Department in writing within thirty (30) days of any change in address and of any change in the authorized representative of the sponsor.

H. Approved sponsors must allow representatives of the Department and the continuing education administrator, in an official capacity, to audit classroom course instruction, correspondence course review sessions, course records, records of examination and attendance rosters. These representatives may attend any course offered for the purpose of the audit without paying a fee.

I. A sponsor shall report to the Director or his designee any administrative action taken against the sponsor in another jurisdiction or by another governmental agency in this State within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

V. Course Approval

A. Approved Sponsors of courses presented for approval shall submit to the Department at least thirty (30) days in advance of the Continuing Education Advisory Board meeting an application for approval, which shall include the following:

(1) a detailed outline of the course;

(2) a timetable, with instruction minutes assigned to each topic;

(3) a sample competency examination if the course is self-study with text reference for each exam question;

(4) course material;

(5) self study courses must include a certification report of the number of words per document, grade level and degree of difficulty of the course;

(6) online courses must include a screen count and number of words per screen; and

(7) a nonrefundable filing fee established by the Department.

No course may be offered until written notification of its approval has been issued by the Department. Incomplete submissions will be disapproved and the application will be returned to the sponsor. The Director has the discretion to develop different standards for approval of courses offered by accredited institutions of higher learning and to waive independent approval of courses offered by nationally recognized industry organizations.

B. Courses will be approved for a period of not more than three (3) years from the approval date. Sponsors may apply to renew course approval.

C. Courses that are submitted for renewal must include all of the information requested in Section V (A) of this regulation and must include the page numbers and sections where updates to course material have been made.

D. Approved sponsors may file an appeal if a course submission is disapproved or if fewer hours are approved than were requested by the sponsor. The appeal must specify the exact disagreement and contain documentation to support the appeal. Appeals must be in writing and must be submitted to the Department within thirty (30) days of receipt of the notice of course disapproval or notice of fewer hours approved. Appeals will be submitted to three representatives of the Continuing Education Advisory Board for review and recommendation to the Department.

VI. Instructor Approval

A. Instructors must be approved by the Department of Insurance before teaching any course. The application packet must be submitted by an approved sponsor thirty (30) days prior to the instructor teaching any course and must include the following:

(1) a properly completed instructor approval application;

(2) documentation of one of the following must be submitted with the application for approval:

(a) a college degree in insurance from an accredited institution of higher learning;

(b) a professional designation of CPCU or CIC for property and casualty approval and ChFC, CFP, FLMI, LUTCF or CLU for life, accident and health approval;

(c) seven or more years of practical experience in the subject matter;

(d) or a college degree and three or more years of practical experience in the subject matter;

(e) five or more years of practical experience in the subject matter and has one or more of the following professional insurance designations or programs in the subject matter for which approval is sought: INS or AAI; or

(f) Insurance Department regulators with a minimum of one year of insurance experience; and

(3) a nonrefundable filing fee to be established by the Department of Insurance.

Incomplete submissions will be returned to the sponsor. B. Instructors will be approved for a period of not more than three (3) years from the approval date. Sponsors may apply to renew instructor approval.

C. Instructors must ensure that attendees do not use class time for any purpose other than learning the material being presented. Instructors should deny credit to anyone who is inattentive or who does not attend the entire classroom session.

D. Instructors must distribute SCID Form 3617 prior to each continuing education classroom session. E. Proctors are responsible for checking an examinee's photograph identification before administering an examination. Proctors are responsible for returning all examination material to the sponsor within two days following the completion of the examination.

F. Instructors/Proctors of correspondence course review sessions must not disclose the examination questions or answers to the examination questions on the competency examination during the review session.

G. An instructor shall report to the Director or his designee any administrative action taken against the instructor in another jurisdiction or by another governmental agency in this State within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

H. Within thirty (30) days, an instructor shall report to the Director any criminal prosecution of the instructor taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

VII. Certification

A. Approved Sponsors of approved courses must submit class rosters to the Continuing Education Administrator according to the following timetable:

1. Approved classroom course or seminar - within thirty (30) days of completion of the course or seminar; and

2. Approved self-study course - within thirty (30) days of the examination completion date. Rosters must be properly completed, typewritten or computer-generated and contain the names and identification numbers of producers who completed all sessions of the approved course, or who successfully completed the competency examination for courses approved for self-study. Incomplete or inaccurate rosters will be returned to the sponsor. Subsequent submissions of any roster that has been returned must include a letter from the sponsor explaining corrections or any changes made.

B. Approved Sponsors of approved courses are required to provide a certification of course completion to each individual who successfully completes an approved course or an approved self-study course within thirty (30) business days after the course is completed or the competency examination results are received. Verification of the accuracy of the certification provided by the approved sponsor remains the responsibility of the producer.

C. A producer who successfully completes an approved course may not repeat the course and receive certification within two years of its original completion date.

D. Instructors of approved classroom courses shall be given a certification equal to the number of hours for which the course is approved. Instructors/Proctors may not be given a certification for conducting review sessions for approved correspondence courses.

E. Producers who accumulate credits in excess of the continuing insurance education requirements may apply these additional credits to the next biennial continuing insurance education period. No more than eighteen (18) credit hours in the line of authority in which they are earned may be carried forward to the next biennial continuing insurance education period. F. No credit will be given for courses taken before they have been approved by the Department. Credit may not be given for courses that have not been renewed by the sponsor.

VIII. Forms

The following items must be on forms specified or approved by the Director: (1) applications for sponsor approval, (2) applications for course approvals and (3) applications for instructor approval. Class completion rosters must be submitted electronically to the CE Administrator. However, individual course completion certificates must be provided to the producer.

IX. Advertising

A. No course may be advertised as an approved course until approval has been received from the Department.

B. Announcements, advertisements and information about courses designated as approved courses by the Department shall contain the statement "This course is approved by the South Carolina Department of Insurance for Continuing Insurance Education Credit" followed by a statement of the number of credit hours and the type of license to which the credit may apply. If the course offering contains material which is not approved, the announcement, advertisement or information must clearly state the amount of course time which is not approved for continuing insurance education credits.

C. Announcements, advertisements or information about approved courses shall contain clear and concise statements about the cost of the course, cancellation procedures, and refund policies.

X. Fees

Every producer subject to continuing insurance education requirements pursuant to Section 38–43–106 of the South Carolina Code of Laws is responsible for payment of a reasonable annual recordkeeping fee to the Continuing Education Administrator for operation of the continuing insurance education program. The license and appointment(s) of any producer who does not pay the continuing education recordkeeping fee by the biennial compliance deadline will lapse on the day following the biennial compliance deadline. The Department may reactivate the license and appointment that has lapsed if within six months of the compliance deadline the continuing education recordkeeping fee has been paid to the Continuing Education Administrator and a $50 penalty has been paid to the Department, and proof of completion of a total of twenty-four hours of continuing education credits has been received. Failure to pay the continuing education recordkeeping fee and a $50 penalty and providing proof of completion of twenty-four hours of continuing education credits within six months of the compliance deadline will result in the license and appointment being canceled. In order to regain licensure status, the producer must retake and pass the appropriate producer licensing examination, complete a new application and pay an application fee to the Department.

XI. Continuing Education Hours

Producers who fail to complete twenty-four hours of approved continuing education credits by the biennial compliance deadline will have their license and appointment(s) suspended on the day following the biennial compliance deadline. Producers may reactivate the license and appointment(s) that have lapsed, if within six months of the compliance deadline, the continuing education recordkeeping fee has been paid to the Continuing Education Administrator and a $50 penalty has been paid to the Department of Insurance and proof of completion of a total of twenty-four hours of continuing education credits has been received. The license and appointment(s) of a producer who does not provide documentation of compliance within six months of the compliance deadline will be canceled. In order to regain licensing status, the producer must retake and pass the appropriate producer licensing examination, complete a new application and pay an application fee to the Department.

XII. Non-Compliance

A. The Director shall have the authority to conduct surveys of producers, approved sponsors, and approved instructors to verify that the approved courses are administered as filed with the Department, and to determine compliance with Section 38–43–106 of the South Carolina Code of Laws and the regulations contained herein.

B. The failure of approved sponsors and instructors to comply with the provisions of Section 38–43–106 of the South Carolina Code of Laws or with the provisions of these regulations may result in a fine of not less than $1,000, suspension of approval, or termination of approval status.

XIII. Hardship Waiver

The request for a hardship waiver must be in writing and must be received by the Department on or before the individual's biennial compliance deadline. Hardship waiver requests may only be granted for good cause shown, with the recommendation of the Continuing Education Administrator and the approval of the Director. For purposes of this section, "good cause" includes, but is not limited to, illness or catastrophic events beyond the control of the producer, which preclude the producer from conducting normal work activities during the biennial compliance period. The producer must provide sufficient documentation that the hardship prevented the producer from conducting normal work activities during the biennial compliance period. A licensed insurance producer who is unable to comply with continuing education due to active military service during the biennial compliance period may request a hardship waiver by submitting a copy of his military orders with the hardship waiver request. Producers who apply for the hardship waiver must still pay the Continuing Education recordkeeping fee to the Continuing Education Administrator by the biennial compliance deadline.

XIV. Administration of Continuing Education Requirements

The Director is responsible for administering the continuing insurance education requirements contained in South Carolina Code of Laws Section 38–43–106 and in this regulation, and is responsible for the approval of courses of instruction which qualify for these purposes. Effective January 1, 2011, the compliance deadline to meet continuing insurance education requirements will be based upon the individual producer's birth month and birth year. To facilitate the transition from all producers

having a May 1 compliance deadline to individual birth month/birth year compliance deadlines, the Director may specify the continuing insurance education requirements with which producers must comply during the transition period ending December 31, 2012. In administering this program, the Director in his discretion, may designate a Continuing Education Administrator within the Department, or, in the alternative, contract with an outside service provider to function as continuing education administrator and to provide record-keeping services.

XV. Effective Date

This regulation shall become effective upon final publication in the *State Register*.

HISTORY: Added by State Register Volume 16, Issue No. 4, eff April 24, 1992; Amended by State Register Volume 26, Issue No. 2, eff February 22, 2002; State Register Volume 29, Issue No. 4, eff April 22, 2005; State Register Volume 34, Issue No. 5, eff May 28, 2010.

69–52. Actuarial Opinion And Memorandum Regulation.

Section I. Purpose

The purpose of this regulation is to prescribe:

A. Requirements for statements of actuarial opinion that are to be submitted in accordance with Section 38–9–180 of the Code of Laws of South Carolina (hereinafter "Standard Valuation Law"), and for memoranda in support thereof;

B. Rules applicable to the appointment of an appointed actuary; and

C. Guidance as to the meaning of "adequacy of reserves."

Section II. Authority

This regulation is issued pursuant to the authority vested in the Director of the Department of Insurance of the State of South Carolina under Section 38–9–180 of the Code of Laws of South Carolina. This regulation will take effect for annual statements for the year 2008.

Section III. Scope

This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the Director shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the Director's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

This regulation shall be applicable to the 2008 Annual Statement and all subsequent annual statements filed with the office of the Director. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6 of this regulation, and a memorandum in support thereof in accordance with Section 7 of this regulation, shall be required each year.

Section IV. Definitions

A. "Actuarial Opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6 of this regulation and with applicable Actuarial Standards of Practice.

B. "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

C. "Annual statement" means that statement required by the Standard Valuation Law to be filed by the company with the office of the Director annually.

D. "Appointed actuary" means an individual who is appointed or retained in accordance with the requirements set forth in Section 5C of this regulation to provide the actuarial opinion and supporting memorandum as required by the Standard Valuation Law.

E. "Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in Section 5D of this regulation.

F. "Company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

G. "Director" means the Director of Insurance of this State.

H. "Qualified actuary" means an individual who meets the requirements set forth in Section 5B of this regulation.

Section V. General Requirements

A. Submission of Statement of Actuarial Opinion

(1) There is to be included on or attached to Page 1 of the annual statement for each year beginning with the 2008 Annual Statement the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 6 of this regulation.

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

B. Qualified Actuary. A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American Academy of Actuaries;

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the Director (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

(a) Violated any provision of, or any obligation imposed by, the insurance statutes of this State or other law in the course of his or her dealings as a qualified actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(d) Submitted to the Director during the past five (5) years, pursuant to this regulation, an actuarial opinion or memorandum that the Director rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

(e) Resigned or been removed as an actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the Director of any action taken by any Director of any other state similar to that under Paragraph (4) above.

C. Appointed Actuary. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the Director timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in Subsection B. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the Director timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in Subsection B. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

D. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this regulation:

(1) Shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and on any additional standards under this regulation, which standards are to form the basis of the statement of actuarial opinion in accordance with this regulation; and

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

E. Liabilities to be Covered.

(1) Under authority of the Standard Valuation Law, the statement of actuarial opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 5, 6 and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in the Standard Valuation Law, the company shall establish the additional reserve.

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

Section VI. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

A. General Description. The statement of actuarial opinion submitted in accordance with this section shall consist of:

(1) A paragraph identifying the appointed actuary and his or her qualifications (see Subsection B(1));

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Subsection B(2)) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Subsection B(3)), supported by a statement of each such expert in the form prescribed by Subsection E; and

(4) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Subsection B(6)).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

(a) If the appointed actuary considers it necessary to state a qualification of his or her opinion;

(b) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(c) If the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release;

(d) If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

B. Recommended Language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the Director dated [insert date]. I meet the Academy

qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

For a consulting actuary, the opening paragraph should include a statement such as:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Director dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

Statement Item		Asset Adequacy Formula Reserves (1)	Tested Amounts Additional Actuarial Reserves (a) (2)	Reserves and Liabilities Analysis Method (b) Other Amount (3)	Total Amount (4)
Exhibit 8					
A	Life Insurance				
B	Annuities				
C	Supplementary Contracts Involving Life Contingencies				
D	Accidental Death Benefit				
E	Disability—Active				
F	Disability—Disabled				
G	Miscellaneous				
	Total (Exhibit 8 Item 1, Page 3)				
Exhibit 9					
A	Active Life Reserve				
B	Claim Reserve				
	Total (Exhibit 9 Item 2, Page 3)				
Exhibit 10					
	Premium and Other Deposit Funds (Column 5, Line 14)				
	Guaranteed Interest Contracts (Column 2, Line 14)				
	Other (Column 6, Line 14)				
2	Supplemental Contracts and Annuities Certain (Column 3, Line 14)				
3	Dividend Accumulations or Refunds (Column 4, Line 14)				
	Total Exhibit 10 (Column 1, Line 14)				
Exhibit 11 Part 1					
1	Life (Page 3, Line 4.1)				
2	Health (Page 3, Line 4.2)				

Statement Item	Asset Adequacy Formula Reserves (1)	Tested Amounts Additional Actuarial Reserves (a) (2)	Reserves and Liabilities Analysis Method (b) Other Amount (3)	Total Amount (4)
Total Exhibit 11, Part 1				
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)				
TOTAL RESERVES				
IMR (General Account, Page ___ Line___)				
(Separate Accounts, Page ___ Line___)				
AVR (Page ___ Line___)		(c)		
Net Deferred and Uncollected Premium				

Notes:

(a) The additional actuarial reserves are the reserves established under Paragraph (2) of Section 5E.

(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Section 5D of this regulation, by means of symbols that should be defined in footnotes to the table.

(c) Allocated amount of Asset Valuation Reserve (AVR).

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

"I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of the experts in the form prescribed by Section 6E.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

"In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The section shall be accompanied by a statement by each person relied upon in the form prescribed by Subsection E.

(6) The opinion paragraph should include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

(a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(b) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(c) Meet the requirements of the Insurance Law and regulation of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

(e) Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the Director, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

or

The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

Note: Choose one of the above two paragraphs, whichever is applicable.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

_____

Telephone Number of Appointed Actuary

_____

Date"

C. Assumptions for New Issues

The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this Section 6.

D. Adverse Opinions

If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or

she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

E. Reliance on Information Furnished by Other Persons

If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

F. Alternate Option

(1) The Standard Valuation Law gives the Director broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of Subsection B(6)(c), the Director may make one or more of the following additional approaches available to the opining actuary:

(a) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the Director chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(b) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the Director for approval of that request have been met." If the Director chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. It shall remain valid until rescinded or modified by the Director. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the Director has not denied the request by that date.

(c) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state."

(i) If the Director chooses to allow this alternative, a formal written list of products (to be added to the table in Item (ii) below) for which the required comparison shall be provided will be published. If a company chooses to use this Actuarial Opinion and Memorandum Regulation alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

(ii) If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under NAIC codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(iii) The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

(iv) If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(v) The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding the above, the Director may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the Director after consultation with the company, the Director may contract an independent actuary at the company's expense to prepare and file the opinion.

Section VII. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary

A. General

(1) In accordance with the Standard Valuation Law, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Director upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the Director.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Section 5B of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the Director requests a memorandum and no such memorandum exists or if the Director finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Director may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Director.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Director; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Director and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Director pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

(5) In accordance with the Standard Valuation Law, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection C. The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. Details of the Memorandum Section Documenting Asset Adequacy Analysis

When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Section 5D of this regulation and any additional standards under this regulation. It shall specify:

(1) For reserves:

(a) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(b) Source of liability in force;

(c) Reserve method and basis;

(d) Investment reserves;

(e) Reinsurance arrangements;

(f) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(g) Documentation of assumptions to test reserves for the following:

(i) Lapse rates (both base and excess);

(ii) Interest crediting rate strategy;

(iii) Mortality;

(iv) Policyholder dividend strategy;

(v) Competitor or market interest rate;

(vi) Annuitization rates;

(vii) Commissions and expenses; and

(viii) Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) For assets:

(a) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(b) Investment and disinvestment assumptions;

(c) Source of asset data;

(d) Asset valuation bases; and

(e) Documentation of assumptions made for:

(i) Default costs;

(ii) Bond call function;

(iii) Mortgage prepayment function;

(iv) Determining market value for assets sold due to disinvestment strategy; and

(v) Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) For the analysis basis:

(a) Methodology;

(b) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(c) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

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

(e) Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) Summary of results; and

(6) Conclusions.

C. Details of the Regulatory Asset Adequacy Issues Summary

(1) The regulatory asset adequacy issues summary shall include:

(a) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(b) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

(c) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

(d) Comments on any interim results that may be of significant concern to the appointed actuary;

(e) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

(f) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

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

D. Conformity to Standards of Practice. The memorandum shall include a statement:

"Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

E. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve

An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

F. Documentation. The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

G. The Director may prescribe additional scenarios for use in the asset adequacy analysis if the Director is not satisfied with the scenarios upon which the asset adequacy opinion is based. If the additional scenarios are to be performed by all licensed companies, the additional required scenarios must be published in the form of a Bulletin.

HISTORY: Added by State Register Volume 17, Issue No. 6, eff June 25, 1993, and takes effect for annual statements for the year 1993. Amended by State Register Volume 32, Issue No. 6, eff June 27, 2008.

69–53. Credit for Reinsurance.

(Statutory Authority: S.C. Code Sections 38–3–110; 38–9–200; 1–23–10 et seq.)

Section I. Purpose.

The purpose of this regulation is to set forth rules and procedural requirements which the director or his designee deems necessary to carry out the provisions of Sections 38–9–190 through 38–9–220. The actions and information required by this regulation are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this State.

Section II. Severability.

If any provisions of this regulation, or the application of the provision to any person or circumstance, is held invalid, the remainder of the regulation, and the application of the provisions to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section III. Reinsurer licensed in this state.

Pursuant to Section 38–9–200(B), the director or his designee shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which was licensed in this State as of any date on which statutory financial statement credit for reinsurance is claimed.

Section IV. Accredited reinsurers.

A. Pursuant to Section 38–9–200(C), the director or his designee shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this State as of any date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer:

1. Files a properly executed Form AR-1 (attached as an exhibit to this regulation) as evidence of its submission to this State's jurisdiction and to this State's authority to examine its books and records;

2. Files with the director or his designee 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 United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

3. Files annually with the director or his designee 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. a. Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the director or his designee within ninety (90) days of its submission; or

b. Maintains a surplus as regards policyholders of less than $20,000,000, and whose accreditation has been approved by the director or his designee.

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

Section V. Reinsurer domiciled and licensed in another state.

A. Pursuant to Section 38–9–200(D), the director or his designee 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:

1. Is domiciled (or, in the case of a United States branch of an alien assuming insurer, is entered through) a state which employs standards regarding credit for reinsurance substantially similar to those applicable under the Code and this regulation;

2. Maintains a surplus as regards policyholders in an amount not less than $20,000,000: and

3. Files a properly executed Form AR-1 with the director or his designee as evidence of its submission to this State'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 which the director or his designee determines equal or exceed the standards of the Code and this regulation.

Section VI. Reinsurers maintaining trust funds.

A. Pursuant to Section 38–9–200(E), the director or his designee 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 United States financial institution as defined in Section 38–9–220, for the payment of the valid claims of its United States domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the director or his designee substantially the same information as that required to be reported on the National Association of Insurance Commissioners annual statement form by licensed insurers, to enable the director or his designee 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 reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Paragraph 2 of this subsection.

2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by trust for at least 3 full years, the director or his designee with principal regulatory oversight of the trust may authorize a reduction in the required trusted 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 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 thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

3. a. The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of:

(1) 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 group's several liabilities attributable to business ceded by U. S. domiciled ceding insurers to any member of the group;

(2) 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 regulation, funds in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States: and

(3) In addition to these trusts, the group shall maintain a trusteed surplus of which $100,000,000 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 (90) days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the director or his designee:

(1) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group: or

(2) If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.

4. a. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (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 (3) years immediately prior to making application for accreditation, shall:

(1) Consist of funds in trust in an amount not 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 and;

(2) Maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group: and

(3) File a properly executed Form AR-1 as evidence of the submission to this State'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.

b. Within ninety (90) days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the director or his designee 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. 1. 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. 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 (30) 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 United States ceding insurers, their assigns and successors in interest;

c. The trust shall be subject to examination as determined by the director or his designee;

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;

e. No later than February 28 of each year the trustees of the trust shall report to the director or his designee 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. a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor 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 claims 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 regulation, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U. S. domiciled insurers that are not 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 Section 38–9–200 and this section shall be valued according to their 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 Section 38–9–220, clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in Section 38–9–220, and investments of the type specified in this subsection, 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 five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under Paragraphs 1.e., 3, 6.b. or 7 of this subsection, and no more than ten percent (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 Section 38–9–200 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 Subparagraphs (b) and (c) of this paragraph if the obligations shall be by law (statutory of 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 paragraph 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 this state 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 Paragraph 1, 2 or 3 of this subsection 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 five percent (5%) of the assets of the trust;

b. An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

c. The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (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 Paragraphs (2)(a) and (2)(c) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

5. As used in this regulation:

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:

(1) 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:

(i) 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. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located: and

(ii) 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. Sections 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. Section 1703: or

(2) 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 Items (1)(i) and (1)(ii) of this subsection;

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:

(1) Its obligations and preferred shares, if any, are eligible as investments under this subsection: and

(2) 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. Sections 78a to 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 paragraph an amount exceeding one percent (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:

(1) 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

(2) 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 one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not exceed ten percent (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. Section 80a are permissible investments if the investment company:

(1) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under Paragraph 1, 2 or 3 of this subsection or invests in securities that are determined by the director or his designee to be substantively similar to the types of securities set forth in Paragraph 1, 2 or 3 of this subsection: or

(2) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under Paragraph 6.a. of this subsection;

b. Investments made by a trust in investment companies under this paragraph shall not exceed the following limitations:

(1) An investment in an investment company qualifying under Subparagraph a.(1) of this paragraph shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust: and

(2) Investments in an investment company qualifying under Subparagraph a.(2) of this paragraph shall not exceed five percent (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 Paragraph 6.a. of this subsection.

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 or his designee), 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 IX of this regulation 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.

Section VII. Credit for reinsurance required by law.

Pursuant to Section 38–9–200(F), the director or his designee shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Sections 38–9–200(B), (C), (D) or (E), 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.

Section VIII. Credit for Reinsurance - Certified Reinsurers

A. Pursuant to South Carolina Code Section 38–9–200 the director or his designee shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state 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 South Carolina Code Section 38–9–200 and X, XI, or XII of this Regulation. 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 or his designee shall require the certified reinsurer to post one hundred percent (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 or his designee. 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:

Line 1: Fire

Line 2: Allied Lines

Line 3: Farmowners multiple peril

Line 4: Homeowners multiple peril

Line 5: Commercial multiple peril

Line 9: Inland Marine

Line 12: Earthquake

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 or his designee 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 or his designee may not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

2. The director or his designee 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 or his designee 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 or his designee pursuant to Subsection C of this section.

b. The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with Subparagraph (4)(h) of this subsection. 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 $250,000,000 and a control fund containing a balance of at least $250,000,000.

c. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the director or his designee. 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 or his designee.

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 or his designee 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 reinsurer);

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

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 (90) 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 statement of the insurance enterprise, on the basis described in paragraph (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. CAAP 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 or his designee will consider audited financial statements for the last three (3) 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 or his designee.

5. Based on the analysis conducted under Subparagraph (4)(e) of a certified reinsurer's reputation for prompt payment of claims, the director or his designee 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 or his designee shall, at a minimum, increase the security the

certified reinsurer is required to post by one rating level under Subparagraph (4)(a) if the director or his designee finds that:

a. More than fifteen percent (15%) of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more which are not in dispute and which exceed $100,000 for each cedent; or

b. The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety (90) days or more exceeds $50,000,000.

6. The assuming insurer must submit a properly executed Form CR-1 (attached as an exhibit to this regulation) as evidence of its submission to the jurisdiction of this state, appointment of the director or his designee as an agent for the service of process in this state, and agreement to provide security for one hundred percent (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 or his designee shall not certify any assuming insurer that is domiciled in a jurisdiction that the director or his designee 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 or his designee, 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 S.C. Code of Laws Section 30–4–10 *et. seq*. and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

a. Notification within ten (10) 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 chances 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 (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 (3) 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 or his designee may reasonably require.

8. Change in Rating or Revocation of Certification

a. In the case of a down grade by a rating agency or other disqualifying circumstances, the director or his designee shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of Subparagraph (4)(a).

b. The director or his designee 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 or his designee 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 or his designee, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the director or his designee 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 or his designee, the director or his designee 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 or his designee, the assuming insurer shall be required to post security in accordance with Section IX 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 7, the director or his designee 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 chance 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 (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the director or his designee 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 or his designee determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the director or his designee shall publish notice and evidence of such recognition in an appropriate manner. The director or his designee 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 or his designee 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 or his designee shall determine the appropriate approach for evaluating the qualifications of such jurisdiction, and create and publish a list of jurisdictions whose reinsurers may be approved by the director or his designee as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the director or his designee 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 or his designee, 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 or his designee.

3. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The director or his designee shall consider this list in determining qualified jurisdiction. If the director or

his designee approves a jurisdiction as qualified that does not appear on the list of qualified jurisdiction, the director or his designee shall provide thoroughly documented justification with respect to the criteria provided under Subsections 8.C(s)(a) to (i).

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 and such additional information as the director requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

2. Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state 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 10 days after receiving notice of the change.

3. The director or his designee 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 or his designee may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the director or his designee 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 (3) months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

E. Mandatory Funding clause. In addition to the clauses required under Section 14 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.

Section IX. Asset or Reduction from liability for reinsurance ceded to an unauthorized assuming insurer not meeting the requirements of Sections III through VIII.

A. Pursuant to Section 38–9–210, the director or his designee shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 38–9–200 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 Section 38–9–220. This security may be in the form of any of the following:

1. Cash;

2. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, 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 Section 38–9–220, 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 company 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 his designee.

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 Sections XII and the applicable portions of Sections X, XI or XII of this regulation have been satisfied.

Section X. Trust agreements qualified under Section IX.

A. As used in this section:

1. "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. 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).

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 Section 38–9–220.

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 under Paragraph 11 and 12 of this subsection.

5. The trust agreement shall be established for the sole benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

a. Receive assets and hold all assets in a safe place;

b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

d. Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account;

e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary: and

f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with

notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee. 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 or his designee), 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 own 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 regulation, 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 one hundred two percent (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 (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in Section 38–9–220 apart from its general assets, in trust for such uses and purposes specified in Subparagraphs a. and b. above as may remain executory after such withdrawal and for any period after the termination date.

12. Notwithstanding other provisions of this regulation, when a trust agreement is established to meet the requirements of Section IX 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:

(1) 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

(2) 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 provisions 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 (10) 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 Subparagraphs a and b of this paragraph as may remain executory after withdrawal and for any period after the termination date.

13. The reinsurance agreement may, but need not, contain the provisions required by Subsection D.1.b. of this section, so long as these required conditions are included in the trust agreement. 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 five percent (5%) of the total to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement.

14. Notwithstanding any other provisions in the trust instrument, if the grantor 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 court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the U. S. beneficiaries of the trust, the assets or any part of them shall be returned to the trustee for distribution in accordance with the trust 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 (90) 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 (90) 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 such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in 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. Such 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:

(1) 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 because of cancellations of such policies;

(ii) 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) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) 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 may also 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:

(1) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the current fair market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

(2) After withdrawal and transfer, the current fair market value of the trust account is no less than one hundred two percent (102%) of the required amount.

b. Provide for the return of any amount withdrawn in excess of the actual amounts required for Subsections D.1.e of this section, and for interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Subsection D.1.e.

c. Permit the award by any arbitration panel or court of competent jurisdiction of:

(1) Interest at a rate different from that provided in Subparagraph b,

(2) Court of arbitration costs,

(3) Attorney's fees, and

(4) Any other reasonable expenses.

3. 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 this Department in compliance with the provisions of this regulation 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.

4. Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to December 31, 1992, will continue to be acceptable until December 31, 1993, at which time the agreements will have to fully comply with this regulation for the trust agreement to be acceptable.

5. The failure of any trust agreement to specifically identify the beneficiary as defined in Subsection A of this section shall not be construed to affect any actions or rights which the director or his designee may take or possess pursuant to the provisions of the laws of this State.

Section XI. Letters of credit qualified under Section IX.

A. The letter of credit must be clean, irrevocable unconditional and issued or confirmed by a qualified United States financial institution as defined in Section 38–9–220. 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 shall also 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 below. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. 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. The 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" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than thirty (30) 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 this State or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500), or any successor publication, and all drafts drawn thereunder 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), or any successor publication, 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 Publication 600 or any other successor publication, occur.

G. If the letter of credit is issued by a qualified United States 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 qualified United States 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 (30) days' notice prior to expiry date for nonrenewal.

H. Reinsurance Agreement Provisions.

1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

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:

(1) 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 insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such 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 insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(iii) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) 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 specific reinsurance remain unliquidated and undischarged ten (10) 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 Subsection H.1.b.(1) of this section as may remain after withdrawal and for any period after the termination date.

c. All of the provisions of Paragraph 1 of this subsection shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

2. Nothing contained in Paragraph 1 of this subsection 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 Paragraph 1.b. of this subsection: and/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.

Section XII. 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.

Section XIII. 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 III, IV, V, VI or IX of this regulation or otherwise in compliance with Section 38–9–200 after the adoption of this regulation unless the reinsurance agreement:

A. 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 Section 38–27–510;

B. Includes a provision pursuant to Section 38–9–200(G) whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution

panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel; and

C. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

Section XIV. Contracts affected.

All new and renewal reinsurance transactions entered into after December 31, 1993, shall conform to the requirements of Sections 38–9–190 through 38–9–220 and this regulation if credit is to be given to the ceding insurer for such reinsurance.

Form AR-1 Certificate of assuming insurer

FORM AR-1

CERTIFICATE OF ASSUMING INSURER

I, _____ (Name of Officer), _____ (Title of Officer) of _____ (Name of Assuming Insurer), the assuming insurer under a reinsurance contract with one or more insurers domiciled in South Carolina hereby certify that _____ (Name of Assuming Insurer) (''Assuming Insurer''):

1. Submits to the jurisdiction of any court of competent jurisdiction in South Carolina for the adjudication of any issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).

2. Designates the director or his designee of South Carolina as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the director or his designee of South Carolina 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 South Carolina reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the director or his designee at least once per calendar quarter.

Dated:

(Name of Assuming Insurer)

BY:

(Name of Officer)

(Title of Officer)

Form CR-1 Certificate of Certified Reinsurer

FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____ (Name of Officer), _____ (Title of Officer)

of _____ (Name of Assuming Insurer), the assuming insurer under a reinsurance agreement with one or more insurers domiciled in South Carolina, in order to be considered for approval in this state, hereby certify that _____ (name of assuming insurer) ("Assuming Insurer"):

1. Submits to the jurisdiction of any court of competent jurisdiction in South Carolina 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 the South Carolina Department of Insurance 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 S.C. Reg. 69–53.

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 statement, regulatory filings, and actuarial opinion in accordance with S.C. Reg. 69–53.

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)

BY: _____

_____ (Name of Officer)

HISTORY: Added by State Register Volume 18, Issue No. 3, eff March 25, 1994. Amended by State Register Volume 29, Issue No. 4, eff April 22, 2005; SCSR 42–5 Doc. No. 4792, eff May 25, 2018.

69–54. Experience Modification for Staff Leasing Services Companies in the Workers Compensation Assigned Risk Plan.

(Statutory Authority: 1976 Code §§ 40–68–120(D), 38–3–110(2), 1–23–10 et seq.)

I. Purpose.

The purpose of this regulation is to implement Section 40-68-120(D), Code of Laws of South Carolina (1976, as amended), for the rating of workers compensation insurance policies issued through the Assigned Risk Plan to staff leasing services companies which have or will establish contracts with client companies. Consistent with Section 40-68-120(D), the purpose of this regulation is to ensure that staff leasing services companies which have workers compensation insurance

coverage through the Assigned Risk Plan pay the appropriate workers compensation premium for the leased employees.

II. Definitions.

The following definitions are consistent with those contained in Section 40-68-10:

A. "Staff Leasing Services Company" means an individual business entity that offers staff leasing services.

B. "Staff Leasing Services" means an arrangement by which employees of a licensee are assigned to work at a client company and in which employment responsibilities are shared by the licensee and the client company. The employee's assignment is intended to be of a long-term or continuing nature, rather than temporary or seasonal in nature, and a majority of the work force at a client company worksite or a specialized group within that work force consists of assigned employees of the licensee.

C. "Assigned Employee" means a person performing services for a client company as affected by a contract between a licensee and client company in which employment responsibilities are shared.

D. "Client Company" means a person that contracts with a licensee and is assigned employees by the licensee under that contract.

E. "Experience Modification Rate" means the rate that would have applied to the client company had such company applied directly for a policy through the Assigned Risk Plan. The experience modification rate includes any surcharges provided for in the Assigned Risk Adjustment Plan (ARAP) as well as all other rating factors and surcharges applicable to policies written in the Assigned Risk Plan.

F. "Assigned Risk Plan" means the voluntary agreement among insurers specified in Section 38-73-540, Code of Law of South Carolina (1976, as amended).

III. General Rules.

A. An insurer that provides workers compensation insurance coverage through the Assigned Risk Plan for staff leasing services companies must provide a separate policy for each client company and the experience modification rate of each individual client company must be separately calculated and maintained.

B. Coverage under a workers compensation insurance policy issued through the Assigned Risk Plan to a staff leasing services company cannot be extended to a client company which is not eligible for coverage through the Assigned Risk Plan.

C. An insurer that provides workers compensation insurance coverage through the Assigned Risk Plan to a staff leasing services company must rate each client company separately for a period of three years after it becomes a client company by applying the experience modification rate of that client company.

D. An insurer that provides workers compensation insurance coverage through the Assigned Risk Plan to a staff leasing services company must, after a client company has been a client company of that staff leasing services company for three years, separately rate the client company with the experience modification rate of the staff leasing services company.

E. If a client company insured under a workers compensation insurance policy issued through the Assigned Risk Plan transfers its employees to another staff leasing services company or obtains other workers compensation insurance coverage, the Assigned Risk Plan insurer must provide the client company's experience modification rate to the new staff leasing services company and to the client company's new workers compensation insurer.

IV. Effective Date.

This regulation shall become effective upon final publication in the State Register. However, workers compensation policies issued to staff leasing services companies which are in force as of the effective date of this regulation and which do not comply with its provisions, have one hundred twenty (120) days to comply.

HISTORY: Added by State Register Volume 19, Issue No. 5, eff May 26, 1995.

69–56. Hurricane, Named Storm or Wind/Hail Deductible.

Under S. C. Code Ann. Section 38–73–70 (1976), the Department of Insurance may make reasonable regulations for the enforcement of Chapter 73 entitled "Property, Casualty, Inland Marine and Surety Rates and Rate-making Organizations."

A. Purpose: The purpose of this regulation is to clarify the process for insurers, including surplus lines insurers, to inform policyholders who purchase personal and commercial property policies of the presence of a hurricane, named storm or wind/hail deductible within their policies. The Department recognizes that an insurer may choose to have separate endorsements for each of hurricane, named storm or wind/hail deductibles or may choose to combine them into one endorsement.

B. Definitions:

(1) Named Storm Deductible is a separate deductible triggered by a weather-related event that has been named, designated or identified by the U.S. National Weather Service or the National Hurricane Center. It only includes a hurricane, tropical storm or tropical depression. Any storm or weather-related event given a name by any other person or entity does not qualify as a named storm, for purposes of a separate deductible. Any winter storm or weather event named or identified by the news media cannot be relied upon to trigger a named storm deductible.

(2) Wind/Hail Deductible is a separate deductible applied to a personal or commercial property insurance policy that applies to losses resulting from the perils of wind or hail, regardless of how named or applied and regardless of whether the deductible is calculated as a percentage of policy limits or a specified dollar amount.

C. No insurer may offer a new property policy to or renew an existing policy of an insured that includes a hurricane, named storm or wind/hail deductible unless the insurer:

(1) includes an example which illustrates how the deductible functions for a policy valued at $100,000 and this illustration will include a clear explanation of the event which will trigger the deductible; and

(2) includes on the face of any policy that contains a separate hurricane, named storm or wind/hail deductible the following statement: THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE, NAMED STORM OR WIND/HAIL LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU. THE ENCLOSED EXAMPLE ILLUSTRATES HOW THE DEDUCTIBLE MIGHT AFFECT YOU. This identical statement shall also appear on the declarations page. The language may be added to the policy by an amendatory endorsement.

D. Renewal Changes: No insurer may change a current property policy at renewal by implementing a hurricane, named storm, or wind/hail deductible or increasing the size of the hurricane, named storm or wind/hail deductible unless:

(1) the insurer includes an example which illustrates how the deductible functions for a policy valued at $100,000 and this illustration must include a clear explanation of the event which will trigger the deductible; and

(2) the named insured signs or initials a disclosure that acknowledges that the named insured has read the example.

E. Regulatory Action. Any violation of this regulation may trigger penalties as set forth in S.C. Code Section 38–2–10.

F. Implementation. This regulation becomes effective upon publication in the State Register and applies to any property insurance policies issued or renewed 120 days following such publication. This regulation supersedes and replaces former regulation 69–56 originally issued in 2000.

HISTORY: Added by State Register Volume 24, Issue No. 6, eff June 23, 2000. Amended by SCSR 44–6 Doc. No. 4878, eff June 26, 2020.

69–57. Valuation of Life Insurance Policies.

Section 1. Purpose.

A. The purpose of this regulation is to provide:

(1) Tables of select mortality factors and rules for their use;

(2) Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

(3) Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

B. The method for calculating basic reserves defined in this regulation will constitute the Commissioners' Reserve Valuation Method for policies to which this regulation is applicable.

Section 2. Authority.

This regulation is issued under the authority of Section 38–9–180 of the Insurance Laws of South Carolina.

Section 3. Applicability.

This regulation shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this regulation, subject to the following exceptions and conditions.

A. Exceptions

(1) This regulation shall not apply to any individual life insurance policy issued on or after the effective date of this regulation if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this regulation, that guarantees the premium rates of the new policy. This regulation also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(2) This regulation shall not apply to any universal life policy that meets all the following requirements:

(a) Secondary guarantee period, if any, is five (5) years or less;

(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in Section 4F and the applicable valuation interest rate; and

(c) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

(3) This regulation shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(4) This regulation shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(5) This regulation shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Conditions

(1) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of Section 6.

(2) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of Section 7.

Section 4. Definitions.

For purposes of this regulation:

A. "Basic reserves" means reserves calculated in accordance with South Carolina Code § 38–9–180 (Standard Valuation Law).

B. "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO

valuation tables, as defined in Subsection F of this section, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the effective date of this regulation and promulgated by regulation by the director for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Section 5B of this regulation.

The length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t (if G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

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

where:

x= original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t= 1, 2, . . . ; *t* is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$= Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}},$$ However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and

$q_{x+k+t-1}$=valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of Section 5B(2) if Section 5B(3) is elected for deficiency reserves.

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

C. "Deficiency reserves" means the excess, if greater than zero, of

(1) Minimum reserves calculated in accordance with South Carolina Code §38-9-180/Standard Valuation Law over

(2) Basic reserves.

D. "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

E. "Maximum valuation interest rates" means the interest rates defined in South Carolina Code §38–9–180 (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

F. "1980 CSO valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

G. "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in Section 7A(3), if any, or else the minimum premium described in Section 7A(4).

H.(1) "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(a) The present value of the death benefits within the segment, plus

(b) The present value of any unusual guaranteed cash value (see Section 6D) occurring at the end of the segment, less

(c) Any unusual guaranteed cash value occurring at the start of the segment, plus

(d) For the first segment only, the excess of the Item (i) over Item (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(2) The length of each segment is determined by the "contract segmentation method," as defined in this section.

(3) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(4) For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

I. "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

J. "Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

K.(1) "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(a) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(b) Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Item (i) over Item (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(2) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

L. "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

Section 5. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves.

A. At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables

with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the director for this purpose). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix; or

(3) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the director for the purpose of calculating basic reserves.

B. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the director). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix of this regulation;

(3) For durations in the first segment, X percent of the select mortality factors in the Appendix, subject to the following:

(a) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(b) X shall not be less than twenty percent (20%);

(c) X shall not decrease in any successive policy years;

(d) X is such that, when using the valuation interest rate used for basic reserves, Item (i) is greater than or equal to Item (ii);

(i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(e) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

(f) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Subsection B(3);

(g) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of Subsection B(3); and

(h) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(i) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Regulation 69–52; and

(ii) The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Subsection B(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American

Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(4) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the director for the purpose of calculating deficiency reserves.

C. This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

D. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

E. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

F. The director may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Regulation 69–52.

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

A. Basic Reserves

Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in Paragraph (1) or (2) below may be made:

(1) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

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

B. Deficiency Reserves

(1) The deficiency reserve at any duration shall be calculated:

(a) On a unitary basis if the corresponding basic reserve determined by Subsection A is unitary;

(b) On a segmented basis if the corresponding basic reserve determined by Subsection A is segmented; or

(c) On the segmented basis if the corresponding basic reserve determined by Subsection A is equal to both the segmented reserve and the unitary reserve.

(2) This subsection shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in Section 5B) and rate of interest.

(3) Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Section 5B.

(4) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

C. Minimum Value

Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

D. Unusual Pattern of Guaranteed Cash Surrender Values

(1) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

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

(a) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(i) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) The mandatory expiration date of the policy; and

(b) The net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(c) The net to gross ratio is equal to Item (i) divided by Item (ii) as follows:

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

(ii) The present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

(3) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(a) One hundred ten percent (110%) of the scheduled gross premium for that year;

(b) One hundred ten percent (110%) of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(c) Five percent (5%) of the first policy year surrender charge, if any.

E. Optional Exemption for Yearly Renewable Term Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection C.

(3) Deficiency reserves.

(a) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(b) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the director for this purpose.

(5) A reinsurance agreement shall be considered YRT reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(6) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

F. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 6C.

(3) Deficiency reserves.

(a) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(b) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the director for this purpose.

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

(a) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(b) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

(6) For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(a) The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(b) The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(c) After the initial period of coverage, the policy meets the conditions of Paragraph (5) above.

(7) If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this regulation.

G. Exemption from Unitary Reserves for Certain *n*-Year Renewable Term Life Insurance Polices. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

(1) The policy consists of a series of *n*-year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(2) The guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

(3) There are no cash surrender values in any policy year.

H. Exemption from Unitary Reserves for Certain Juvenile Policies

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(1) At issue, the insured is age twenty-four (24) or younger;

(2) Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and

(3) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

Section 7. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period.

A. General

(1) Policies with a secondary guarantee include:

(a) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(b) A policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the director for this purpose; or

(c) A policy with any combination of Subparagraph (a) and (b).

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subsections B and C below shall be recalculated from issue to reflect these changes.

(3) Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(4) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the

policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(5) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Section 5B(2), (3), and (4) may not be used to calculate the one-year valuation premiums.

(6) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

B. Basic Reserves for the Secondary Guarantees

Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in Section 4B.

C. Deficiency Reserves for the Secondary Guarantees

Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in Section 6B with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

D. Minimum Reserves

The minimum reserves during the secondary guarantee period are the greater of:

(1) The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) The minimum reserves required by other rules or regulations governing universal life plans.

Section 8. This regulation will take effect January 1, 2002.

Appendix

SELECT MORTALITY FACTORS

This appendix contains tables of select mortality factors that are the bases to which the respective percentage of Section 5A(2), 5B(2) and 5B(3) are applied.

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male nonsmoker, (3) male smoker, (4) female aggregate, (5) female nonsmoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.

For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table in this Appendix, plus twenty percent (20%) of the appropriate female table in this Appendix.

SELECT MORTALITY FACTORS

Male, Aggregate

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

Male, Aggregate

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

Male, Aggregate

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

Male, Non-Smoker

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

Male, Non-Smoker

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

Male, Non-Smoker

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

Male, Smoker

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

Male, Smoker

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

Male, Smoker

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

Female, Aggregate

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

Female, Aggregate

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

Female, Aggregate

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

Female, Non-Smoker

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

Female, Non-Smoker

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

Female, Non-Smoker

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

Female, Smoker

Issue **Duration**

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

Female, Smoker

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

Female, Smoker

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

HISTORY: Added by State Register Volume 25, Issue No. 5, Part 2, eff January 1, 2002.

69–57.1. Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits.

(Statutory Authority: 1976 Code §§ 38–3–110, 38–9–180, 38–63–510 et seq., 1–23–110 et seq.)

Section 1. Authority

Section 2. Purpose

Section 3. Definitions

Section 4. 2001 CSO Mortality Table

Section 5. Conditions

Section 6. Applicability of the 2001 CSO Mortality Table to South Carolina Insurance Regulation 69–57

Section 7. Gender-Blended Tables

Section 8. Separability

Section 9. Effective Date

Section 1. Authority

This regulation is promulgated by the Director of Insurance pursuant to South Carolina Code Sections 38–9–180 and 38–63–510 et seq. as well as Regulation 69–57, Valuation of Life Insurance Policies.

Section 2. Purpose

The purpose of this regulation is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with South Carolina Code Section 38–9–180 and Section 38–63–510 et seq. as well Regulation 69–57, Valuation of Life Insurance Policies.

Section 3. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

C. "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

D. "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

E. "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

Section 4. 2001 CSO Mortality Table

A. At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this regulation, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2005 and before the date specified in Subsection B to which South Carolina Code Sections 38–9–180 and 38–63–510 et seq. and South Carolina Insurance Regulation 69–57 are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

B. Subject to the conditions stated in this regulation, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which South Carolina Code Sections 38–9–180 and 38–63–510 et seq. and Regulation 69–57 are applicable.

C. The new minimum basis for the computation of values related to extended term benefits shall be the 2001 CSO Mortality Table, subject to the transition dates for use of the 2001 CSO Mortality Tables set forth in this section.

Section 5. Conditions

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

(1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by South Carolina Code Section 38–9–180 and use

composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(3) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of Section 6 and South Carolina Insurance Regulation 69–57 relative to use of the select and ultimate form.

D. When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the Director shall be based on an asset adequacy analysis as specified in South Carolina Insurance Regulation 69–52. A Director may exempt a company from this requirement if it only does business in this state and in no other state.

Section 6. Applicability of the 2001 CSO Mortality Table to South Carolina Insurance Regulation 69–57

A. The 2001 CSO Mortality Table may be used in applying South Carolina Insurance Regulation 69–57 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in Section 4 of this regulation unless otherwise noted, the references in this section are to the South Carolina Insurance Regulation 69–57:

(1) Section 3A(2)(b): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) Section 4B: All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Section 6A(4) of this regulation. The value of "qx + k + t-1" is the valuation mortality rate for deficiency reserves in policy year k + t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) Section 5A: The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(4) Section 5B: The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in Sections 5B(3)(a) to (i). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant Actuarial Standards of Practice.

(5) Section 6C: The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

(6) Section 6E(4): The calculations specified in Section 6E shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(7) Section 6F(4): The calculations specified in Section 6F shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(8) Section 6G(2): The calculations specified in Section 6G shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(9) Section 7A(1)(b): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

B. Nothing in this section shall be construed to expand the applicability of South Carolina Insurance Regulation 69–57 to include life insurance policies exempted under Section 3A of South Carolina Insurance Regulation 69–57.

Section 7. Gender-Blended Tables

A. For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2005, that utilizes the same premium rates and charges for male and female lives or is

issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection of the regulation.

B. The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002.

C. It shall not, in and of itself, be a violation of South Carolina Code of Laws Chapter 57 of Title 38 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Section 8. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 9. Effective Date

This regulation shall be effective January 1, 2005.

HISTORY: Added by State Register Volume 30, Issue No. 3, eff March 24, 2006.

69–57.2. Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities.

(Statutory Authority: 1976 Code §§ 38–9–180 and 1–23–10 et seq.)

Section 1. Authority

Section 2. Purpose

Section 3. Definitions

Section 4. 2001 CSO Preferred Class Structure Table

Section 5. Conditions

Section 6. Separability

Section 7. Effective Date

Section 1. Authority

This regulation is promulgated by the Director of Insurance pursuant to South Carolina Code of Laws Section 38–90–180, the Standard Valuation Law, and Sections 5A and 5B of South Carolina Regulation 69–57, Valuation of Life Insurance Policies.

Section 2. Purpose

The purpose of this regulation is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with South Carolina Code of Laws Section 38–90–180, the Standard Valuation Law, and Sections 5A and 5B of South Carolina Regulation 69–57,Valuation of Life Insurance Policies.

Section 3. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)* and supplemented by the 2001 CSO Preferred Class Structure Mortality Table defined below in Subsection B. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2001 CSO Mortality Table include the following:

(1) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(2) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(3) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(4) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

B. "2001 CSO Preferred Class Structure Mortality Table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2001 CSO Nonsmoker and Smoker Tables, as adopted by the NAIC at the September, 2006 national meeting and published in the *NAIC Proceedings* {*3rd Quarter 2006*}. Unless the context indicates otherwise, the "2001 CSO Preferred Class Structure Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

C. "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information; demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers; and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

Section 4. 2001 CSO Preferred Class Structure Table

At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this regulation, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. No such election shall be made until the company demonstrates at least 20% of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this rule, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of the NAIC model regulation, "Recognition of the 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits Model Regulation."

Section 5. Conditions

A. For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

B. For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

C. Unless exempted by the Director, every authorized insurer using the 2001 CSO Preferred Class Structure Table shall annually file with the Director, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the Director, statistical reports showing mortality and such other information as the Director may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports shall be established by the Director or the Director may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the Director.

Section 6. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 7. Effective Date

The effective date of this regulation is January 1, 2007.

HISTORY: Added by State Register Volume 31, Issue No. 5, eff May 25, 2007.

69–57.3. Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values.

Section 1. Authority

Section 2. Scope

Section 3. Purpose

Section 4. Definitions

Section 5. Minimum Valuation Mortality Standards

Section 6. Minimum Valuation Interest Rate Standards

Section 7. Minimum Valuation Method Standards

Section 8. Transition Rules

Section 9. Effective Date

Section 1. Authority

This regulation is promulgated by the Director of Insurance pursuant to South Carolina Code Sections 38–9–180 and 38–63–510 et seq. as well as Regulation 69–57.

Section 2. Scope

This rule applies to preneed insurance contracts, as defined in section 4 of this regulation, and to similar policies and certificates.

Section 3. Purpose

The purpose of this regulation is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products.

Section 4. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for males and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance

Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. "Ultimate 1980 CSO" means the Commissioners' 1980 Standard Ordinary Life Valuation Mortality Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

C. "Preneed insurance" means any life insurance policy or certificate, which has for its purpose the furnishing or performance of funeral services, or the furnishing or delivery of personal property, merchandise, services of any nature in connection with the final disposition of a dead human body, to be furnished or delivered at a time determinable by the death of the person whose body is to be disposed of, but does not mean the furnishing of a cemetery lot, crypt, niche, mausoleum, grave marker or monument.

Section 5. Minimum Valuation Mortality Standards

For preneed insurance contracts, as defined in section 4C, and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

Section 6. Minimum Valuation Interest Rate Standards

A. The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in South Carolina Code Section 38–9–180.

B. The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in South Carolina Code Section 38–63–510 et seq.

Section 7. Minimum Valuation Method Standards

A. The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in South Carolina Code Section 38–9–180.

B. The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in South Carolina Code Section 38–63–510 et seq.

Section 8. Transition Rules

A. For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

B. If an insurer elects to use the 2001 CSO as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

(1) A complete list of all preneed policy forms that use the 2001 CSO as a minimum standard;

(2) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed policies issued after the effective date and using the 2001 CSO as a minimum standard, develops adequate reserves. (For the purpose of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies); and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO as a minimum standard for reserves.

C. Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

Section 9. Effective Date

This regulation is applicable to preneed insurance policies and certificates and similar contracts and certificates, as specified in section 2, issued on or after January 1, 2009.

HISTORY: Added by State Register Volume 33, Issue No. 4, eff April 24, 2009.

69–58. Privacy of Consumer Financial and Health Information.

(Statutory Authority: 1976 Code Sections 1–23–110 et seq., 38–3–110, and Title V of Pub. Law 102–106, the Gramm-Leach-Bliley Act)

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ARTICLE I
GENERAL PROVISIONS

Section 1. Authority.

This regulation is promulgated pursuant to the authority granted by Sections 38–3–110 of the South Carolina Insurance Code and Title V of Pub. Law 102–106, the Gramm-Leach-Bliley Act.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 2. Purpose and Scope.

A. Purpose.

This regulation governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

(1) Requires a licensee to provide notice to individuals about its privacy policies and practices;

(2) Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

(3) Provides methods for individuals to prevent a licensee from disclosing that information.

B. Scope.

This regulation applies to:

(1) Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

(2) All nonpublic personal health information.

C. Compliance.

A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act (PL 102–106) may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in such other state.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 3. Rule of Construction.

The examples in this regulation and the sample clauses in Appendix A, and the Federal Model Privacy Form in Appendix B of this regulation are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this regulation.

Licensees may rely on use of the Federal Privacy Form in Appendix B, consistent with the attached instructions, as a safe harbor of compliance with the privacy notice content requirements of this regulation.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 4. Definitions.

As used in this regulation, unless the context requires otherwise:

A. "Affiliate" means any company that controls, is controlled by or is under common control with another company.

B.(1) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(2) Examples.

(a) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(i) Presents the information in the notice in clear, concise sentences, paragraphs, and sections:

(ii) Uses short explanatory sentences or bullet lists whenever possible;

(iii) Uses definite, concrete, everyday words and active voice whenever possible;

(iv) Avoids multiple negatives;

(v) Avoids legal and highly technical business terminology whenever possible; and

(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(i) Uses a plain-language heading to call attention to the notice;

(ii) Uses a typeface and type size that are easy to read;

(iii) Provides wide margins and ample line spacing;

(iv) Uses boldface or italics for key words; and

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

C. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

D. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

E.(1) "Consumer" means an individual 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, or that individual's legal representative.

(2) Examples.

(a) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if:

(i) (I) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(II) The individual is a claimant under an insurance policy issued by the licensee;

(III) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(IV) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(ii) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under Sections 15, 16, and 17 of this regulation.

(e) Provided that the licensee provides the initial, annual and revised notices under Section 10 of this regulation to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, or workers' compensation policyholder and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under Sections 15, 16, and 17 of this regulation, an individual is not the consumer of the licensee solely because he or she is:

(i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(ii) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee;

(iii) A claimant covered by a workers' compensation plan.

(f)(i) The individuals described in Subparagraph (e)(i) through (ii) of this Paragraph are consumers of a licensee if the licensee does not meet all the conditions of Subparagraph (e).

(ii) In no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through (ii) above, be deemed to be customers for purposes of this regulation.

(g) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(h) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

F. "Consumer reporting agency" has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

G. "Control" means:

(1) Ownership, control or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(2) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(3) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines.

H. "Customer" means a consumer who has a customer relationship with a licensee.

I. (1) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(2) Examples.

(a) A consumer has a continuing relationship with a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(i) The consumer applies for insurance but does not purchase the insurance;

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction;

(iii) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(vi) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(viii) For the purposes of this regulation, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

J. "Director" means the director of the South Carolina Department of Insurance.

K. (1) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial institution does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

(ii) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

L.(1) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

M. "Health care" means:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(2) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

N. "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

O. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(1) The past, present or future physical, mental or behavioral health or condition of an individual;

(2) The provision of health care to an individual; or

(3) Payment for the provision of health care to an individual.

P. (1) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

(2) Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for a insurance product or service.

Q. (1) "Licensee" means all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state.

(2)(a) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(b) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(c) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

(3)(a) Subject to Subparagraph (b), "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to S.C. Code Section 38–45–10 et. seq.

(b) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation provided:

(i) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under Section 15 of this regulation, except as permitted by Section 16 or 17 of this regulation; and

(ii) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW."

R.(1) "Nonaffiliated third party" means any person except:

(a) A licensee's affiliate; or

(b) A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

(2) Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

S. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

T.(1) "Nonpublic personal financial information" means:

(a) Personally identifiable financial information; and

(b) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(2) Nonpublic personal financial information does not include:

(a) Health information;

(b) Publicly available information, except as included on a list described in Subsection T(1)(b) of this section; or

(c) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

(3) Examples of lists.

(a) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(b) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

U. "Nonpublic personal health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

V.(1) "Personally identifiable financial information" means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

(2) Examples.

(a) Information included. Personally identifiable financial information includes:

(i) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(ii) Account balance information and payment history;

(iii) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(iv) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(v) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(vi) Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

(vii) Information from a consumer report.

(b) Information not included. Personally identifiable financial information does not include:

(i) Health information;

(ii) A list of names and addresses of customers of an entity that is not a financial institution; and

(iii) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

W.(1) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(a) Federal, state or local government records;

(b) Widely distributed media; or

(c) Disclosures to the general public that are required to be made by federal, state or local law.

(2) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(a) That the information is of the type that is available to the general public; and

(b) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(3) Examples.

(a) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(b) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(c) Reasonable basis.

(i) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(ii) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

ARTICLE II
PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

Section 5. Initial Privacy Notice to Consumers Required.

A. Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in Subsection E of this section; and

(2) Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by Sections 16 and 17.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under Subsection A(2) of this section if:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by Sections 16 and 17, and the licensee does not have a customer relationship with the consumer; or

(2) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the licensee establishes a customer relationship.

(1) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(2) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(a) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of Subsection A of this section as follows:

(1) The licensee may provide a revised policy notice, under Section 9, that covers the customer's new insurance product or service; or

(2) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection A of this section.

E. Exceptions to allow subsequent delivery of notice.

(1) A licensee may provide the initial notice required by Subsection A(1) of this section within a reasonable time after the licensee establishes a customer relationship if:

(a) Establishing the customer relationship is not at the customer's election; or

(b) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) Examples of exceptions.

(a) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(c) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to Section 11. If the licensee uses a short-form initial notice for non-customers according to Section 7D, the licensee may deliver its privacy notice according to Section 7D(3).

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 6. Annual Privacy Notice to Customers Required.

A. (1) General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(2) Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year

following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

B. Exception to general rule. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 15, 16, or 17 and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section or Section 5 shall not be required to provide an annual disclosure under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

C. (1) Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(2) Examples.

(a) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(b) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

(c) For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(d) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

D. Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to Section 11.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 7. Information to Be Included in Privacy Notices.

A. General rule. The initial, annual and revised privacy notices that a licensee provides under Sections 5, 6 and 9 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects;

(2) The categories of nonpublic personal financial information that the licensee discloses;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 15 (and no other exception in Sections 16 and 17 applies to that disclosure), a

separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(6) An explanation of the consumer's right under Section 12A to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(9) Any disclosure that the licensee makes under Subsection B of this section.

B. Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under Sections 16 and 17, the licensee is not required to list those exceptions in the initial or annual privacy notices required by Sections 5 and 6. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples.

(1) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from a consumer reporting agency.

(2) Categories of nonpublic personal financial information a licensee discloses.

(a) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in Paragraph (1), as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(i) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

(ii) Transaction information, such as information about balances, payment history and parties to the transaction; and

(iii) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(3) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(a) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(4) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in Section 15 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection A(5) of this section if it:

(a) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Subsection A(2) of this section, as applicable; and

(b) States whether the third party is:

(i) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(ii) A financial institution with whom the licensee has a joint marketing agreement.

(5) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under Sections 16 and 17 the licensee may simply state that fact, in addition to the information it shall provide under Subsections A(1), A(8), A(9), and Subsection B of this section.

(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-form initial notice with opt out notice for non-customers.

(1) A licensee may satisfy the initial notice requirements in Sections 5A(2) and 8C for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in Section 8.

(2) A short-form initial notice shall:

(a) Be clear and conspicuous;

(b) State that the licensee's privacy notice is available upon request; and

(c) Explain a reasonable means by which the consumer may obtain that notice.

(3) The licensee shall deliver its short-form initial notice according to Section 11. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to Section 11.

(4) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(a) Provides a toll-free telephone number that the consumer may call to request the notice; or

(b) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future disclosures. The licensee's notice may include:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample clauses and Federal Model Privacy Form. Sample clauses illustrating some of the notice content required by this section and the Federal Model Privacy Form are included in Appendix A and Appendix B of this regulation.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 8. Form of Opt Out Notice to Consumers and Opt Out Methods.

A.(1) Form of opt out notice. If a licensee is required to provide an opt out notice under Section 12A, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c) A reasonable means by which the consumer may exercise the opt out right.

(2) Examples.

(a) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(i) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in Section 7A(2) and (3), and states that the consumer can opt out of the disclosure of that information; and

(ii) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(b) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(i) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(ii) Includes a reply form together with the opt out notice;

(iii) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(iv) Provides a toll-free telephone number that consumers may call to opt out.

(c) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(i) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(ii) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(d) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

B. Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with Section 5.

C. Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with Section 5, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

D. Joint relationships.

(1) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in Paragraph (5) of this subsection).

(2) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(a) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(b) Permit each joint consumer to opt out separately.

(3) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(4) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(5) Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(a) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(b) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(c) Permit John and Mary to make different opt out directions. If the licensee does so:

(i) It shall permit John and Mary to opt out for each other;

(ii) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(iii) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

E. Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

F. Continuing right to opt out. A consumer may exercise the right to opt out at any time.

G. Duration of consumer's opt out direction.

(1) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(2) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

H. Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to Section 11.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 9. Revised Privacy Notices.

A. General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under Section 5, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice;

(3) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

B. Examples.

(1) Except as otherwise permitted by Sections 15, 16, and 17, a licensee shall provide a revised notice before it:

(a) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(b) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(c) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(2) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to Section 11.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 10. Privacy Notices to Group Policyholders

Unless a licensee is providing privacy notices directly to covered individuals described in Section 4E(2)(e)(i), (ii), or (iii), a licensee shall provide initial, annual and revised notices to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder or workers' compensation policyholder, in the manner described in Sections 5 through 9 of this regulation, describing the licensee's privacy practices with respect to nonpublic personal information about individuals covered under the policies, contracts or plans.

HISTORY: Added by State Register Volume 42, Issue No. 1, Doc. No. 4805, eff January 26, 2018.

Editor's Note

Former R 69-58 § 10 transferred to R 69–58 § 11 by SCSR42–1 Doc. No. 4805, eff January 26, 2018.

Section 11. Delivery.

A. How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

B. (1) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(2) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(a) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

C. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(1) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(2) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

D. Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

E. Retention or accessibility of notices for customers.

(1) For customers only, a licensee shall provide the initial notice required by Section 5A(1), the annual notice required by Section 6A, and the revised notice required by Section 9 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(2) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

F. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

G. Joint relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of Sections 5A, 6A and 9A, respectively, by providing one notice to those consumers jointly.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 10 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

ARTICLE III
LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 12. Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties.

A.(1) Conditions for disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(a) The licensee has provided to the consumer an initial notice as required under Section 5;

(b) The licensee has provided to the consumer an opt out notice as required in Section 8;

(c) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 15, 16 and 17.

(3) Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(a) By mail. The licensee mails the notices required in Paragraph (1) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(b) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Paragraph (1) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(c) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in Paragraph (1) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

B. Application of opt out to all consumers and all nonpublic personal financial information.

(1) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(2) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

C. Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 11 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 13. Limits on Re-disclosure and Reuse of Nonpublic Personal Financial Information.

A. (1) Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in Sections 16 or 17 of this regulation, the licensee's disclosure and use of that information is limited as follows:

(a) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(b) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(c) The licensee may disclose and use the information pursuant to an exception in Sections 16 or 17 of this regulation, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B. (1) Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in Sections 16 or 17 of this regulation, the licensee may disclose the information only:

(a) To the affiliates of the financial institution from which the licensee received the information;

(b) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(c) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(2) Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in Sections 16 or 17:

(a) The licensee may use that list for its own purposes; and

(b) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the

financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in Sections 16 or 17, such as to the licensee's attorneys or accountants.

C. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in Sections 16 or 17 of this regulation, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to the licensee's affiliates;

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) The third party may disclose and use the information pursuant to an exception in Sections 16 or 17 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in Sections 16 or 17 of this regulation, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 12 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 14. Limits on Sharing Account Number Information for Marketing Purposes.

A. General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(2) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(3) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples.

(1) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(2) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 13 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

ARTICLE IV
EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 15. Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing.

A. General rule.

(1) The opt out requirements in Sections 8 and 12 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(a) Provides the initial notice in accordance with Section 5; and

(b) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in Sections 16 or 17 in the ordinary course of business to carry out those purposes.

(2) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of Paragraph (1)(b) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in Sections 16 or 17 in the ordinary course of business to carry out that joint marketing.

B. Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under Subsection A of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

C. Definition of "joint agreement." For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 14 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 16. Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions.

A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(3) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(4) Reinsurance or stop loss or excess loss insurance.

B. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate or acceptable method:

(a) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(b) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(c) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(d) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(e) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(f) In connection with:

(i) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

(ii) The transfer of receivables, accounts or interests therein; or

(iii) The audit of debit, credit or other payment information.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 15 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 17. Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information.

A. Exceptions to opt out requirements. The requirements for initial notice to consumers in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply when a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2)(a) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

(b) To protect against or prevent actual or potential fraud or unauthorized transactions;

(c) For required institutional risk control or for resolving consumer disputes or inquiries;

(d) To persons holding a legal or beneficial interest relating to the consumer; or

(e) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Record keeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

(5)(a) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

(b) From a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(7)(a) To comply with federal, state or local laws, rules and other applicable legal requirements;

(b) To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

(c) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

B. Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under Section 8F.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 16 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

ARTICLE V
RULES FOR HEALTH INFORMATION

Section 18. When Authorization Required for Disclosure of Nonpublic Personal Health Information.

A. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

B. Nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the Director to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 17 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 19. Authorizations.

A. A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(1) The identity of the consumer or customer who is the subject of the nonpublic personal health information;

(2) A general description of the types of nonpublic personal health information to be disclosed;

(3) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or revocation or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 18 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 20. Authorization Request Delivery.

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to Section 11, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information and nonpublic personal health information pursuant to Section 18A.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 19 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 21. Relationship to Federal Rules.

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the U.S. Department of Health and Human Services 45 CFR Part 160 (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of this Article V.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 20 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 22. Relationship to State Laws.

Nothing in this article shall preempt or supersede existing state law related to medical records, health or insurance information privacy.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 21 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

ARTICLE VI
ADDITIONAL PROVISIONS

Section 23. Protection of Fair Credit Reporting Act.

Nothing in this regulation shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under Section 603 of that Act.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 22 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 24. Nondiscrimination

A. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

B. A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

HISTORY: Added by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Editor's Note
Former R 69–58 § 24 transferred to R 69–58 § 26 by SCSR42–1 Doc. No. 4805, eff January 26, 2018.

Section 25. Violation.

Persons violating the provisions of this regulation shall have committed an unfair trade practice and shall be subject to the penalties set forth in Chapter 57 of Title 38.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 23 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 26. Severability.

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 24 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

Section 27. Effective Date.

A. Effective date. This regulation is effective upon publication of the final regulation in the State Register.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Former R 69–58 § 25 transferred and amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

APPENDIX A
SAMPLE CLAUSES

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A–1. Categories of information a licensee collects (all institutions).

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(1) to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A–1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–2. Categories of information a licensee discloses (institutions that disclose outside of the exceptions).

A licensee may use one of these clauses, as applicable, to meet the requirement of Section 7A(2) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–3. Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions).

A licensee may use this clause, as applicable, to meet the requirements of Sections 7A(2), (3), and (4) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in Sections 16 and 17.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–4. Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions).

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(3) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17, as well as when permitted by the exceptions in Sections 16 and 17.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];
- Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and
- Others, such as [provide illustrative examples, such as "non-profit organizations"].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–5. Service provider/joint marketing exception.

A licensee may use one of these clauses, as applicable, to meet the requirements of Section 7A(5) related to the exception for service providers and joint marketers in Section 15 If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–6. Explanation of opt out right (institutions that disclose outside of the exceptions).

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(6) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as call the following toll-free number: (insert number)].

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

A–7. Confidentiality and security (all institutions).

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(8) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

HISTORY: Added by State Register Volume 25, Issue No. 7, eff July 27, 2001. Amended by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

App. B. FEDERAL MODEL PRIVACY FORM

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the Federal Model Privacy Form, if the Form is accurate for each institution that uses the Form. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

General Instructions

1. How the Model Privacy Form is used.

(a) The Model Form may be used, at the option of a "licensee", including a group of licenses or other financial institutions that use a common privacy notice, to meet the content requirements of the privacy notice and opt-out notice set forth in Sections 7 and 8 of this Regulation.

(b) The Model Form is a standardized form, including page layout, content, format, style, pagination, and shading. Licensees seeking to obtain the safe harbor through use of the Model Form may modify it only as described in these Instructions.

(c) Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act (FCRA), codified at 15 U.S.C. §§ 1681–1681x, such as a requirement to permit a consumer to opt out of disclosures to affiliates, or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

(d) The word "customer" may be replaced by the word "member," whenever it appears in the Model Form, as appropriate.

2. The Contents of the Model Privacy Form

The Model Form consists of two pages, which may be printed on both sides of a single sheet of paper or may appear on two separate pages. Where a licensee provides a long list of licensees or financial institutions at the end of the Model Form in accordance with Instruction B3(a)(i), or provides additional information in accordance with Instruction B3(c) and such list or additional information exceeds the space available on Page Two of the Model Form, such list or additional information may extend to a third page.

(a) Page One. The first page consists of the following components:

(1) Date last revised (upper right-hand corner)

(2) Title

(3) Key frame (Why? What? How?)

(4) Disclosure table ("Reasons we can share your personal information")

(5) "To limit our sharing" box, as needed, for the licensee's opt-out information

(6) "Questions" box, for customer service contact information

(7) Mail-in opt-out form, as needed

(b) Page Two. The second page consists of the following components:

(1) Heading (Page 2)

(2) Frequently Asked Question ("Who we are" and "What we do")

(3) Definitions

(4) "Other important information" box, as needed

3. The format of the Model Privacy Form

The format of the Model Form may be modified only as described below:

(a) Easily readable type font. Licensees that use the Model Form must use an easily readable type font. While a number of factors together produce easily readable font, licensees are required to use a minimum of 10-point font (unless otherwise expressly permitted in these Instructions) and sufficient spacing between lines.

(b) Logo. A licensee may include a corporate logo on any page of the notice, so long as it does not interfere with the readability of the Model Form or the space constraints of each page.

(c) Page size and orientation. Each page of the Model Form must be printed in portrait orientation, the size of which must be sufficient to meet the layout and minimum font size requirements, with sufficient white space on the top, bottom, and sides of the content.

(d) Color. The Model Form must be printed on white or light color paper (such as cream) with black or other contrasting ink color. Spot color may be used to achieve visual interest, so long as the color contrast is distinctive and the color does not detract from the readability of the Model Form. Logos may also be printed in color.

(e) Languages. The Model Form may be translated into languages other than English.

B. Information Required in the Model Privacy Form

The information in the Model Form may be modified only as described below:

1. Name of licensee or group of affiliated licensees or institutions providing the notice.

Insert the name of the licensee providing the notice, or a common identity of the affiliated licenses or financial institutions jointly providing the notice on the form, wherever [name of licensee] appears.

2. Page One

(a) Last revised date. The licensee must insert in the upper right-hand corner the date on which the notice was last revised. The information shall appear in minimum 8-point font as "rev. [month/year]" using either the name or number of the month, such as "rev. July 2016" or "rev. 7/16."

(b) General instructions for the "What?" box.

(i) The bulleted list identifies the types of personal information that the licensee collects and shares. All licensees must use the term "Social Security Number" in the first bullet.

(ii) A licensee must use five (5) of the following terms, to complete the bulleted list: income; account balances; payment history; transaction history; transaction or loss history; credit history; credit scores; assets; investment experiences; credit —based insurance scores; insurance claim history; medical information; overdraft history; purchase history; account transactions; risk tolerance; medical related debts; credit card or other debt; mortgage rates and payments; retirement assets; checking account information; employment information; wire transfer instructions.

(c) General instructions for the disclosure table. The left column lists reasons for sharing or using personal information. Each reason correlates to a specific legal provision described in Paragraph 2(d) of this Instruction. In the middle column, each licensee must provide a "Yes" or "no" response that accurately reflects its information-sharing policies and practices with respect to the reason listed on the left. In the right column, each licensee must provide in each box one of the following three (3) responses, as applicable, that reflects whether a consumer can limit such sharing:

"Yes," if it is required to or voluntarily provides an opt-out; "No," if it does not provide an opt-out; or

"We don't share," if it answers "No" in the middle column.

Only the sixth row ("For our affiliates to market to you") may be omitted at the option of the licensee. See Paragraph 2(d)(6) of this instruction.

(d) Specific disclosures and corresponding legal provisions

(i) For our everyday business purposes. This reason incorporates sharing information under Sections 16 and 17 of this Regulation and with service providers pursuant to Section 15 of this Regulation, other than the disclosures described in Paragraphs (2)(d)(ii) or (2)(d)(iii) of this instruction.

(ii) For our marketing purposes. This reason incorporates sharing information with service providers by a licensee for its own marketing pursuant to Section 15 of this Regulation. A licensee that shares for this reason may choose to provide an opt-out.

(iii) For joint marketing with other financial companies. This reason incorporates sharing information under joint marketing agreements between 2 or more licensees or financial institutions and with any service provider used in conjunction with such agreement pursuant to Section 15 of this Regulation. A licensee that shares for this reason may choose to provide and opt-out.

(iv) For our affiliates' everyday business purposes- information about transactions and experiences. This reason incorporates sharing information specified in Sections 603(d)(2)(A)(i) and (ii) of the FCRA. A licensee that shares information for this reason may choose to provide an opt-out.

(v) For our affiliates' everyday business purposes- information about creditworthiness. This reason incorporates sharing information pursuant to Section 603(d)(2)(A)(iii) of the FCRA. A licensee that shares information for this reason must provide an opt-out.

(vi) For our affiliates to market to you. This reason incorporates sharing information specified in Section 24 of the FCRA. This reason may be omitted from the disclosure table when the licensee does not have affiliates (or does not disclose personal information to its affiliates); the licensee's affiliates do not use personal information in a manner that requires an opt-out; or the licensee provides the affiliate marketing notice separately. Licensees that include this reason must provide an opt-out of indefinite duration. A licensee that is required to provide an affiliate marketing opt-out, but does not include that opt-out in the Model Form under this part, must comply with Section 624 of the FCRA and this Regulation with respect to the initial notice and opt-out and any subsequent renewal notice and opt-out. A licensee not required to provide an opt-out under this subparagraph may elect to include this reason in the Model Form.

(vii) For nonaffiliates to market to you. This reason incorporates sharing described in Sections 8 and 12(a) of this Regulation. A licensee that shares personal information for this reason must provide an opt-out.

(e) To limit our sharing. A licensee must include this section of the Model Form only if it provides an opt-out. The word "choice" may be written in either the singular or plural, as appropriate. Licensees must select one or more of the applicable opt-out methods described: telephone, such as by a toll-free number; a web site; or use of a mail-in opt-out form. Licensees may include the word "toll-free" before telephone, as appropriate. A licensee that allows consumer to opt out online must provide either a specific web address that takes consumers directly to the opt-out page or a general web address that provides a clear and conspicuous direct link to the opt-out page. The opt-out choices made available to the consumer who contacts the licensee through these methods must correspond accurately to the "Yes" response in the third column of the disclosure table. In the part entitled "Please note," licensees may insert a number that is 30 days or greater in the space marked "[30]." Instructions on voluntary or state privacy law opt-out information are in Paragraph 2(g)(v) of these Instructions.

(f) Questions box. Customer service contact information must be inserted as appropriate where [phone number] or [web site] appear. Licenses may elect to provide either a phone number, such as a toll-free number, or a web address, or both. Licensees may include the words "toll-free" before the telephone number, as appropriate.

(g) Mail-in opt-out form. Licensees must include this mail-in form only if they state in the "To limit our sharing" box that consumers can opt out by mail. The mail-in form must provide opt-out options that correspond accurately to the "Yes" responses in the third column of the disclosure table. Licensees that require consumers to provide only name and address may omit the section identified as "[account #]." Licensees that require additional or different information, such as a random opt-out election should modify the "[account#]" reference accordingly. This includes licensees that require customers with multiple accounts to identify each account to which the opt-out should apply. A licensee must enter its opt-out mailing address in the far right of this form (see version3); or below the form (see version 4). The reverse side of the mail-in opt-out form must not include any content of the Model Form.

(i) Joint accountholder. Only licensees that provide their joint accountholders the choice to opt out for only one accountholder, in accordance with Paragraph 3(a)(5) of these Instructions, must include in the far left column of the mail-in form the following statement:

If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below

[] Apply my choice(s) only to me.

The word "choice" may be written in either the singular or plural, as appropriate. Licensees that provide insurance products or services provide this option, and elect to use the Model Form may substitute the word "policy" for "account" in this statement. Licensees that do not provide this option may eliminate this left column from the mail-in form.

(ii) FRCA Section 603(d)(2)(A)(iii) opt-out. If the licensee shares personal information pursuant to Section 603(d)(A)(iii) of the FCRA, it must include in the mail-in opt-out form the following statement:

[] Do not share information about my creditworthiness with you affiliates for their everyday business purposes.

(iii) FCRA Section 624 opt-out. If the licensee uses Section 624 of the FCRA, in accordance with paragraph 2(d)(6) of these Instructions, it must include in the mail-in opt-out form the following statement:

[] Do not allow your affiliates to use my personal information to market to me.

(iv) Nonaffiliate opt-out. If the licensee shares personal information pursuant to Section 12(a) of this Regulation], it must include in the mail-in opt-out form the following statement:

[] Do not share my personal information with nonaffiliates to market their products and services to me.

(v) Additional opt-outs. Licensees that use the disclosure table to provide opt out options beyond those required by Federal law must provide those opt-outs in this section of the Model Form. A licensee that chooses to offer an opt-out for its own marketing in the mail-in opt-out form must include one of the two following statements:

[] Do not share my personal information to market to me. OR

[] Do not use my personal information to market to me.

A licensee that chooses to offer an opt-out for joint marketing must include the following statement:

[] Do not share my personal information with other financial institutions to jointly market to me.

(h) Barcodes. A licensee may elect to include a barcode and/or "tagline" (an internal identifier) in 6-point type at the bottom of page one, as needed for information internal to the licensee, so long as these do not interfere with the clarity or text of the form.

3. Page Two

(a) General Instructions for the Questions. Certain Questions on the Model Form may be customized as follows:

(i) "Who is providing this notice?" This question may be omitted where only one licensee provides the Model Form and that licensee is clearly identified in the title on Page One. Two or more licensees or financial institutions that jointly provide the Model Form must use this question to identify themselves as required by Section 11(F) of this Regulation. Where the list of licensees or financial institutions exceeds four (4) lines, the licensee must describe in the response to this question the general types of licensees or financial institutions jointly providing the notice and must separately identify those licensees or financial institutions, in minimum 8-point font, directly following the "Other important information" box, or, if that box is not included in the licensee's form, directly following the "Definitions." The list may appear in a multi-column format.

(ii) "How does [name of licensee] protect my personal information?" The licensee may only provide additional information pertaining to its safeguards practices following the designated response to this question. Such information may include information about the licensee's use of cookies or other measures it uses to safeguard personal information. Licensees are limited to a maximum of 30 additional words.

(iii) "How does [name of licensee] collect my personal information?" Licensees must use five (5) of the following terms to complete the bulleted list for this question: open an account; deposit money; pay your bills; apply for a loan; use your credit or debit card; seek financial or tax advice; apply for insurance; pay insurance premiums; file an insurance claim; seek advice about your investments; buy securities from us; sell securities to us; direct us to buy securities; direct us to sell your securities; make deposits or withdrawals from your account; enter into an investment advisory contract; give us you income information; provide employment information; tell us about your investment or retirement portfolio; tell us about your investment or retirement earnings; apply for financing; apply for a lease; provide account information; give us you contact information; pay us by check; give us your wage statements; provide your mortgage information; make a wire transfer; tell us who receives the money; tell us where to send the money; show your government-issued ID; show your driver's license; order a commodity futures or option trade.

Licensees that collect personal information from their affiliates and/or credit bureaus must include the following statement after the bulleted list; "We also collect your personal information from others, such as credit bureaus, affiliates, or other companies." Licensees that do not collect personal information from their affiliates or credit bureaus but do collect information from other companies must include

the following statement instead: "We also collect your personal information from other companies." Only licensees that do not collect any personal information from affiliates, credit bureaus, or other companies can omit both statements.

(iv) "Why can't I limit all sharing?" Licensees that describe state privacy law provisions in the "Other important information" box must use the bracketed sentence: "See below for more on your rights under state law." Other licensees must omit this sentence.

(v) "What happens when I limit sharing for an account I hold jointly with someone else?" Only licensees that provide opt-out options must use this question. Other licensees must omit this question. Licensees must choose one of the following tow statements to respond to this question: "Your choices will apply to everyone on your account — unless you tell us otherwise." "Licensees may substitute the word policy" for "account" in these statements.

(b) General Instructions for the Definitions. The licensee must customize the space below the responses to the three definitions in this section. This specific information must be in italicized lettering to set off the information from the standardized definitions.

(i) Affiliates. As required by Section 7(A)(3) of this Regulation, where [affiliate information] appears, the licensee must:

(a) If it has no affiliates, state: "[name of licensee] has no affiliates";

(b) If it has affiliates but does not share personal information with them, state: "[name of licensee] does not share with our affiliates"; or

(c) If it shares with its affiliates, state, as applicable: "Our affiliates include companies with a [common corporate identity of licensee] name; financial companies such as [insert illustrative list of companies]; nonfinancial companies, such as [insert illustrative list of companies]; and others, such as [insert illustrative list]."

(ii) Nonaffiliates. As required by Section 7(c)(3) of this Regulation, where [nonaffiliated information] appears, the licensee must:

(a) If it does not share with nonaffiliated third parties, state: "[name of licensee] does not share with nonaffiliates so they can market to you"; or

(b) If it shares with nonaffiliated third parties, state, as applicable: "Nonaffiliates we share with can include [list categories of companies such as mortgage companies, insurance companies, direct marketing companies, and nonprofit organizations]."

(iii) Joint Marketing. As required by Section 15 of this Regulation, where [joint marketing] appears, the licensee must:

(a) If it does not engage in joint marketing, state: "[name of licensee] doesn't jointly market", or

(b) If it shares personal information for joint marketing, state, as applicable: "Our joint marketing partners include [list categories of companies such as credit card companies]."

(c) General instruction for the "Other important information" box. This box is optional. The space provided for information in this box is not limited, and an additional page may be used if necessary. Only the following types of information can appear in this box:

(i) State and/or international privacy law information; and/or

(ii) A form by which the consumer may acknowledge receipt of the notice.

Rev. [insert date]

Version 1:

Model Form with No Opt-Out

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores] When you are *no longer* our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share **customers'** personal information to run their everyday business. In the section below, we list the reasons financial companies can share their **customers'** personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes- such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes- to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes- information about your transactions and experiences		
For our affiliates' everyday business purposes- information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

Questions?	Call [phone number] or go to [web site]
Who we are	
Who is providing this notice?	[insert]
What we do	
How does [name of licensee] protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does [name of licensee] collect my personal information?	We collect your personal information, for example, when you [open an account] or [deposit money] [pay your bills] or [apply for a loan] [use your credit or debit card] [We also collect your personal information from other companies.] OR

	[We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes — information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 2: Model Form with Opt-Out by telephone and/or Online

Rev. [insert date]

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores] When you are *no longer* our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes-		

such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	
For our marketing purposes- to offer our products and services to you	
For joint marketing with other financial companies	
For our affiliates' everyday business purposes- information about your transactions and experiences	
For our affiliates' everyday business purposes- information about your creditworthiness	
For our affiliates to market to you	
For nonaffiliates to market to you	

To limit our sharing	Call [phone number] — our menu will prompt you through your choice(s) or Visit us online: [website] **Please note:** If you are a *new* customer, we can begin sharing your information [30] days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call [phone number] or go to [web site]

Who we are	
Who is providing this notice?	[insert]
What we do	
How does **[name of licensee]** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does **[name of licensee]** collect my personal information?	We collect your personal information, for example, when you [open an account] or [deposit money] [pay your bills] or [apply for a loan] [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes — information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you

	State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
What happens when I limit sharing for an account I hold jointly with someone else?	[Your choices will apply to everyone on your account.] OR [Your choices will apply to everyone on your account — unless you tell us otherwise.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 3: Model Form with Mail-in Opt-Out Form

Rev. [insert date]

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores]
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes- such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes- to offer our products and services to you		
For joint marketing with other financial companies		

For our affiliates' everyday business purposes- information about your transactions and experiences	
For our affiliates' everyday business purposes- information about your creditworthiness	
For our affiliates to market to you	
For nonaffiliates to market to you	

To limit our sharing	Call **[phone number]** — our menu will prompt you through your choice(s) or Visit us online: **[website] or** Mail the form below **Please note:** If you are a *new* customer, we can begin sharing your information **[30]** days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call **[phone number]** or go to **[web site]**

Mail-in Form	
Leave Blank OR [If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below. ☐ Apply my choices only to me]	Mark any/all you want to limit: ☐ Do not share information about my creditworthiness with your affiliates for their everyday business purposes. ☐Do not allow your affiliates to use my personal information to market to me. ☐Do not share my personal information with nonaffiliates to market their products and services to me. Name Address City, State, Zip [Account #]
Mail To:	[Name of Licensee] [Address] [City],[ST][ZIP]

Who we are	
Who is providing this notice?	[insert]
What we do	
How does **[name of licensee]** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. **[insert]**
How does **[name of licensee]** collect my personal information?	We collect your personal information, for example, when you **[open an account]** or **[deposit money]** **[pay your bills]** or **[apply for a loan]** **[use your credit or debit card]** **[We also collect your personal information from other companies.]** OR

	[We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes — information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing**. [See below for more on your rights under state law.]**
What happens when I limit sharing for an account I hold jointly with someone else?	**[Your choices will apply to everyone on your account**.] OR **[Your choices will apply to everyone on your account — unless you tell us otherwise.]**
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 4: Optional Mail-in Form

Mail-in Form	
Leave Blank OR [If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below. ☐ Apply my choices only to me]	Mark any/all you want to limit: ☐ Do not share information about my creditworthiness with your affiliates for their everyday business purposes. ☐Do not allow your affiliates to use my personal information to market to me. ☐Do not share my personal information with nonaffiliates to market their products and services to me. Name Address City, State, Zip [Account #]
Mail To:	[Name of Licensee] [Address 1], [Address 2], [City],[ST][ZIP]

HISTORY: Added by SCSR 42–1 Doc. No. 4805, eff January 26, 2018.

69–60. Captive Insurance Companies.

Section 1. Purpose and Authority.

The purpose of this regulation is to set forth the financial and reporting requirements which the director or his designee deems necessary for the regulation of captive insurance companies, as authorized by the South Carolina Code of Laws. Reference hereinunder to "company" shall mean captive insurance company or companies, unless otherwise specified.

Section 2. Annual Reporting Requirements.

An association captive insurance company doing business in this State shall annually submit to the director or his designee a report of its financial condition, verified by oath of two of its executive officers. The report shall be that required by S.C. Code Ann. Section 38–13–80.

A pure or industrial insured captive insurance company doing business in this State shall annually submit to the director or his designee a report of its financial condition, verified by oath of two of its executive officers. The report shall be that prescribed by the director or his designee as "Captive Annual Statement: Pure or Industrial Insured".

Section 3. Annual Audit.

All companies shall have an annual audit by an independent certified public accountant, authorized by the director or his designee, and shall file such audited financial report with the director or his designee on or before June 30 for the year ending December 31 immediately preceding.

The annual audit report shall be considered part of the company's annual report of financial condition except with respect to the date by which it must be filed with the director or his designee.

The annual audit shall consist of the following:

(A) Opinion of Independent Certified Public Accountant

Financial statements furnished pursuant to this section shall be examined by independent certified public accountants in accordance with generally accepted auditing standards as determined by the American Institute of Certified Public Accountants.

The opinion of the independent certified public accountant shall cover all years presented.

The opinion shall be addressed to the company on stationery of the accountant showing the address of issuance, shall bear original manual signatures and shall be dated.

(B) Report of Evaluation of Internal Controls

This report shall include an evaluation of the internal controls of the company relating to the methods and procedures used in the securing of assets and the reliability of the financial records, including but not limited to, such controls as the system of authorization and approval and the separation of duties.

The review shall be conducted in accordance with generally accepted auditing standards and the report shall be filed with the director or his designee.

(C) Accountant's Letter

The accountant shall furnish the company, for inclusion in the filing of the audited annual report, a letter stating:

(a) That he is independent with respect to the company and conforms to the standards of his profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and pronouncements of the Financial Accounting Standards Board.

(b) The general background and experience of the staff engaged in audit including the experience in auditing captives or other insurance companies.

(c) That the accountant understands that the audited annual report and his opinions thereon will be filed in compliance with this regulation with the Department.

(d) That the accountant consents to the requirements of Section 6 of this regulation and that the accountant consents and agrees to make available for review by the director or his designee, or his appointed agent, the work papers as defined in Section 6.

(e) That the accountant is properly licensed by an appropriate state licensing authority and that he is a member in good standing in the American Institute of Certified Public Accountants.

(D) Financial Statements

Statements required shall be as follows:

(a) Balance sheet,

(b) Statement of gain or loss from operations,

(c) Statement of changes in financial position,

(d) Statement of changes in capital paid up, gross paid in and contributed surplus and unassigned funds (surplus), and

(e) Notes to financial statements.

The notes to financial statements shall be those required by generally accepted accounting principles, and shall include:

(1) A reconciliation of differences, if any, between the audited financial report and the statement or form filed with the director or his designee.

(2) A summary of ownership and relationship of the company and all affiliated corporations or companies insured by the captive.

(3) A narrative explanation of all material transactions and balances with the company.

(E) Certification of Loss Reserves and Loss Expense Reserves

The annual audit shall include an opinion as to the adequacy of the company's loss reserves and loss expense reserves.

The individual who certifies as to the adequacy of reserves shall be approved by the director or his designee and shall be a Fellow of the Casualty Actuarial Society, a member in good standing of the American Academy of Actuaries, or an individual who has demonstrated his competence in loss reserve evaluation to the director or his designee.

Certification shall be in such form as the director or his designee deems appropriate.

Section 4. Designation of Independent Certified Public Accountant.

Companies, after becoming subject to this regulation, shall within ninety days report to the director or his designee in writing, the name and address of the independent certified public accountant retained to conduct the annual audit set forth in this regulation.

Section 5. Notification of Adverse Financial Condition.

A company shall require the certified public accountant to immediately notify in writing an officer and all members of the Board of Directors of the company of any determination by the independent certified public accountant that the company has materially misstated its financial condition in its report to the director or his designee as required in S.C. Code Ann. Section 38–90–70. The company shall furnish such notification to the director or his designee within five working days of receipt thereof.

Section 6. Availability and Maintenance of Working Papers of the Independent Certified Public Accountant.

Each company shall require the independent certified public accountant to make available for review by the director or his designee, or his appointed agent, the work papers prepared in the conduct of the audit of the company. The company shall require that the accountant retain the audit work papers for a period of not less than five years after the period reported upon.

The aforementioned review by the director or his designee shall be considered investigations and all working papers obtained during the course of such investigations shall be confidential. The company shall require that the independent certified public accountant provide photocopies of any of the working papers which the Department considers relevant. Such working papers may be retained by the Department.

"Work Papers" as referred to in this section include, but are not necessarily limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and his employees in the conduct of their examination of the company.

Section 7. Deposit Requirement.

Whenever the director or his designee deems that the financial condition of the company warrants additional security, he may require a company to deposit with the Department cash or securities which satisfy the requirements of S.C. Code Ann. Section 38–9–80 or, alternatively, to furnish the director or his designee a clean irrevocable letter of credit issued by a bank chartered by the State of South Carolina or a member bank of the Federal Reserve System and approved by the director or his designee.

The company may receive interest or dividends from said deposit or exchange the deposits for others of equal value with the approval of the director or his designee.

If such company discontinues business, the director or his designee shall return such deposit only after being satisfied that all obligations of the company have been discharged.

Section 8. Organizational Examination.

In addition to the processing of the application, an organizational investigation or examination may be performed before an applicant is licensed. Such investigation or examination shall consist of a general survey of the company's corporate records, including charter, bylaws and minute books; verification of capital and surplus; verification of principal place of business; determination of assets and liabilities; and a review of such other factors as the director or his designee deems necessary.

Section 9. Reinsurance.

Any captive insurance company authorized to do business in this State may take credit for reserves on risks ceded to a reinsurer subject to the following limitations:

(A) No credit shall be allowed for reinsurance where the reinsurance contract does not result in the complete transfer of the risk or liability to the reinsurer.

(B) No credit shall be allowed, as an asset or a deduction from liability, to any ceding insurer for reinsurance unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract reinsured without diminution because of the insolvency of the ceding insurer.

Reinsurance under this section shall be effected through a written agreement of reinsurance setting forth the terms, provisions and conditions governing such reinsurance.

The director or his designee in his discretion may require that complete copies of all reinsurance treaties and contracts be filed and/or approved by him.

Section 10. Insurance Managers and Intermediaries.

No person shall, in or from within this State, act as an insurance manager, broker, agent, salesman, or reinsurance intermediary for captive business without the authorization of the director or his designee. Application for such authorization must be on a form prescribed by the director or his designee.

Section 11. Directors.

Every company shall report to the director or his designee within thirty days after any change in its executive officers or directors, including in its report a statement of the business and professional affiliations of any new executive officer or director.

No director, officer, or employee of a company shall, except on behalf of the company, accept, or be the beneficiary of, any fee, brokerage, gift, or other emolument because of any investment, loan, deposit, purchase, sale, payment or exchange made by or for the company, but such person may receive reasonable compensation for necessary services rendered to the company in his or her usual private, professional or business capacity.

Any profit or gain received by or on behalf of any person in violation of this section shall inure to and be recoverable by the company.

Section 12. Conflict of Interest.

Each company chartered in this State is required to adopt a conflict of interest statement for officers, directors and key employees. Such statement shall disclose that the individual has no outside commitments, personal or otherwise, that would divert him from his duty to further the interests of the company he represents but this shall not preclude such person from being a director or officer in more than one insurance company.

Each officer, director, and key employee shall file such disclosure with the Board of Directors yearly.

Section 13. Rescission of Captive License.

The director or his designee may, subject to the provisions of this section, by order rescind the license of the company:

(A) if the company has not commenced business according to its plan of operation within two years of being licensed; or

(B) if the company ceases to carry on insurance business in or from within South Carolina; or

(C) at the request of the company; or

(D) for any reason provided in S.C. Code Ann. Section 38–90–90.

Before the director or his designee rescinds the license of a company under (A) or (B) of this section, the director or his designee shall give the company notice in writing of the grounds on which he proposes to cancel the license, and shall afford the company an opportunity to make objection in writing within the period of thirty days after receipt of notice. The director or his designee shall take into consideration any objection received by him within that period and, if he decides to cancel the license, cause the order of cancellation to be served on the company.

Section 14. Acquisition of Control of or Merger with Domestic Company.

No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire in the open market or otherwise, any voting security of a domestic company if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such company; and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic company without the prior written approval of the director or his designee. In considering any application for acquisition of control or merger with a domestic company, the director or his designee shall consider all of the facts and circumstances surrounding the application as well as the criteria for establishment of a company set out in this chapter.

Section 15. Change of Business.

Any change in the nature of the captive business from that stated in the company's plan of operation filed with the director or his designee upon application requires prior approval from the director or his designee.

Any change in any other information filed with the application must be filed with the director or his designee but does not require prior approval.

HISTORY: Added by State Register Volume 25, Issue No. 6, eff June 22, 2001.

69–61. Service Contracts.

I. Purpose and Scope.

A. This regulation establishes rules and standards to regulate service contracts marketed in the state of South Carolina. This regulation does not apply to:

1. warranties;

2. maintenance agreements;

3. commercial transactions;

4. warranties, service contracts, or maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by the Public Service Commission or the Department of Health and Environmental Control;

5. service contracts sold or offered for sale to persons other than consumers;

B. Except for the registration requirements in Section 38-78-30(C), providers and related service contract sellers, administrators, and other persons marketing, selling, or offering to sell service contracts are exempt from state licensing requirements.

C. Motor vehicle manufacturer's service contracts on the motor vehicle manufacturer's products shall comply with Sections 38–78–50 (A) and (D), to (N), 38–78–60, and 38–78–100 of the South Carolina Code.

II. Definitions.

The terms defined in Section 38–78–20 of the South Carolina Code have those same meanings when used in this regulation.

III. Registration and Financial Security Requirements.

A. Each provider of service contracts sold in this State shall file a registration with the Director on a form prescribed by the Director. Each provider shall pay to the department a non-refundable fee of two hundred dollars annually. Service contracts registration expires annually on September 30.

B. Each provider shall be responsible for insuring all service contracts under a reimbursement insurance policy issued by an insurer authorized to transact insurance business in this State or issued pursuant to Section 38–45–110 of the South Carolina Code.

C. As an alternative to subsection "B" above, a provider may:

1. Maintain a funded reserve account for its obligations under its service contracts issued and outstanding in this State which is subject to examination and review by the director and must amount to at least forty percent of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts; and

2. Place in trust with the director a financial security deposit having a value of not less than five percent of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than twenty-five thousand dollars, consisting of one of the following:

a. a surety bond issued by an authorized surety;

b. securities of the type eligible for deposit by authorized insurers in this State;

c. cash (cashier check only); or

d. an irrevocable letter of credit issued by a qualified financial institution as defined by Section 38–9–220 of the South Carolina Code.

D. As an additional alternative to subsections "B" and "C" above, a provider may maintain, or its parent company maintain, a net worth or stockholder's equity of one hundred million dollars.

1. In electing this option, the provider must, upon request, provide the Director with a copy of the provider's, or the provider's parent company's, most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission (SEC) within the last calendar year. If the provider's parent company's Form 10-K, Form 20-F or audited financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this State.

2. If the provider or its parent company does not file with the SEC, the provider must, upon request, provide the Director with a copy of the provider's or the provider's parent company's audited financial statements which show a net worth of the provider or its parent company of at least one hundred million dollars.

IV. Reimbursement Insurance Policies.

A. Reimbursement insurance policies insuring service contracts issued, sold, or offered for sale in this State shall conspicuously state that the insurer that issued the policy shall either reimburse or pay on behalf of the provider any covered sums the provider is legally obligated to pay or, in the event of the provider's nonperformance, shall provide the service which the provider is legally obligated to perform according to the provider's contractual obligations under the service contracts issued or sold by the provider.

B. In the event a covered service is not provided by the service contract provider within sixty days of proof of loss by the service contract holder, the contract holder is entitled to apply directly to the reimbursement insurance company.

C. Service contracts insured under a reimbursement insurance policy pursuant to Section 38–78–30 (D)(1) of the South Carolina Code shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement insurance policy." The service contract shall also conspicuously state the name and address of the insurer.

D. Service contracts not insured under a reimbursement insurance policy pursuant to Section 38-78-30(D)(1) of the South Carolina Code shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed by the full faith and credit of the provider." A claim against the provider shall also include a claim for return of the unearned provider fee. The service contract shall also conspicuously state the name and address of the provider.

E. Insurers issuing reimbursement insurance to providers are deemed to have received the premiums for such insurance upon the payment of provider fees by consumers for service contracts issued by such insured providers. Insurers which issued a reimbursement insurance policy may seek indemnification or subrogation against a provider if the issuer pays, or is obligated to pay, the service contract holder sums that the provider was obligated to pay pursuant to the provisions of the service contract or under a contractual agreement.

V. General Provider Operation Requirements.

A. A provider may, but is not required to, appoint an administrator or other designee to be responsible for any or all of the administration of service contracts and compliance with this chapter.

B. A service contract must not be issued, sold, or offered for sale in this State unless the provider or its designee has:

1. provided a receipt for, or other written evidence of, the purchase of the service contract to the contract holder and

2. provided a copy of the service contract to the service contract holder within a reasonable period of time from the date of purchase.

VI. Record Maintenance.

A. A provider shall maintain accurate accounts, books, and records concerning transactions regulated under this chapter which shall include:

1. copies of each type of service contract issued;

2. the name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder;

3. a list of the locations where service contracts are marketed, sold or offered for sale; and

4. recorded claims files which shall contain at least the dates and description of claims related to the service contracts.

B. Except as provided in of Section VI(C) of this regulation, the provider shall retain all records required to be maintained for at least one year after the specified period of coverage has expired. The records may be, but are not required to be, maintained on a computer disk or other record keeping technology. If records are maintained in other than hard copy, the records must be capable of duplication to legible hard copy at the request of the Director.

C. A provider discontinuing business in this State shall maintain its records until it furnishes the director satisfactory proof that it has discharged all obligations to contract holders in this State.

D. Upon request of the Director, the provider shall make available all accounts, books and records concerning service contracts sold by the provider which are necessary to enable the director to reasonably determine compliance or noncompliance with the law.

VII. Required Disclosures.

A. Service contracts marketed, issued, sold, offered for sale, made, proposed to be made, or administered in this State shall be written, printed or typed in clear, understandable language that is easy to read and shall disclose the requirements in this section as applicable.

B. Service contracts shall identify any administrator, if different from the providers, the provider obligated to perform the service under the contract, the service contract seller, and the service contract holder to the extent that the name of the service contract holder has been furnished by the service contract holder. The identities of such parties are not required to be preprinted on the service contract and may be added to the service contract at the time of sale.

C. Service contracts shall conspicuously state the total purchase price and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

VIII. Voiding of Contracts.

A. Service contracts shall require the provider to permit the service contract holder to return the service contract within twenty days of the date the service contract was mailed to the service contract holder or within ten days of delivery if the service contract is delivered to the service contract holder at the time of sale or within a longer time period permitted under the service contract. Upon return of the service contract to the provider within the applicable time period, if no claim has been made under the service contract prior to its return to the provider, the service contract is void and the provider shall refund to the service contract holder, or credit the account of the service contract holder, with the full purchase price of the service contract. The right to void the service contract is not transferable and shall apply only to the original service contract purchaser. A ten percent penalty per month shall be added to a refund that is not paid or credited within forty-five days after return of the service contract to the provider.

B. If the provider cancels the service contract, the provider shall mail a written notice to the contract holder at the last known address of the service contract holder contained in the records of the provider at least fifteen days prior to cancellation by the provider. Prior notice is not required if the reason for cancellation is nonpayment of the provider fee, a material misrepresentation by the service contract holder to the provider, or a substantial breach of duties by the service contract holder relating to the covered product or its use. The notice shall state the effective date of the cancellation and the reason for the cancellation.

C. An insurer that issued a reimbursement insurance policy may not terminate the policy until a notice of termination in accordance with Chapter 75, Title 38, of the South Carolina Code has been mailed or delivered to the Director. The termination of a reimbursement insurance policy does not reduce the issuer's responsibility for service contracts issued by providers before the date of the termination.

IX. Limitation on Provider Name.

No provider licensed after October 1, 2000, may use in its name the words "insurance," "casualty," "guaranty," "surety," "mutual," or any other words descriptive of the insurance, casualty, guaranty, or surety business or a name deceptively similar to the name or description of any insurance or surety corporation or any other provider. A previously licensed provider that uses the prohibited language in its name shall conspicuously include in its service contracts a statement in substantially the following form: "This agreement is not an insurance contract".

X. Prohibited Acts.

A. A provider or its representative in its service contracts or literature may not make, permit, or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted, in connection with the sale, offer to sell, or advertisement of a service contract.

B. A person such as a bank, savings and loan association, lending institution, manufacturer, or seller of any product shall not require the purchase of a service contract as a condition of a loan or a condition for the sale of any property.

XI. Enforcement.

A. The Director may examine at any time each provider, administrator, insurer, or other person as to compliance with the requirements of Chapter 78, Article 38 of the South Carolina Code and the quality of services offered. The organization being examined under this Section shall pay the charges incurred in the examination, including the expenses of the Director and the expenses and compensation of his examiners and assistants.

B. The Director may take action, which is necessary or appropriate to enforce the provisions of this chapter and the Director's regulations and orders and to protect service contract holders in this State.

1. If a service contract provider violates a provision of this chapter, the Director may:

a. order the service contract provider to cease and desist from committing the violation;

b. issue an order prohibiting a service contract provider from selling or offering for sale service contracts;

c. issue an order imposing a civil penalty; or

d. any combination of these.

2. A person aggrieved by an order issued under this section may request a hearing before the Director. The hearing request must be filed with the Director within twenty days of the date the Director's order is effective. Pending the hearing and the decision by the Director, the director shall suspend the effective date of the order. At the hearing, the burden is on the Director to show why the order issued pursuant to this section is justified. If the Director upholds the issuance of the order, the person may file an appeal with the Administrative Law Judge Division.

C. The Director may bring an action under the Administrative Law Judge Division or in circuit court for an injunction or other appropriate relief to enjoin threatened or existing violations of this regulation or of the Director's orders. An action filed under this section may also seek restitution on behalf of persons aggrieved by a violation of this regulation or orders of the Director.

D. A person in violation of this regulation or an order of the Director may be assessed a civil penalty not to exceed one thousand dollars per violation and no more than ten thousand dollars in the aggregate for all violations of a similar nature; provided, however, that if a person is found by a court of competent jurisdiction to have been in willful violation of this chapter or an order or regulation of the director, then such person is subject to a penalty of one thousand dollars per violation with no aggregate limit.

E. For purposes of this section, violations of a similar nature, which are considered technical and unintentional by the Department of Insurance lacking the requisite willful intent, are subject to the ten thousand dollar aggregate penalty limit and are defined as a violation which consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the act, conduct, or practice which is determined to be a violation of this chapter occurred.

HISTORY: Added by Register Volume 25, Issue 6, eff June 22, 2001.

Editor's Note

2004 Act No. 202, § 3, provides as follows:

"Wherever the term 'Administrative Law Judge Division' appears in any provision of law, regulation, or other document, it must be construed to mean the Administrative Law Court established by this act."

69–62. Closeout and Termination of the SCAAIP.

(Statutory Authority: 1976 Code § 38–91–10 et seq.)

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69–62.1. Purpose and Applicability

This regulation applies to automobile property and casualty insurance business transacted by the South Carolina Associated Auto Insurers Plan (SCAAIP). The purpose of this regulation is to provide for the termination and orderly transition of business from the SCAAIP to the AAIP of SC.

HISTORY: Added by State Register Volume 31, Issue No. 4, eff April 27, 2007.

69–62.2. Definitions

A. *Accounting and Statistical Requirements Manual* means the South Carolina Associated Insurers Plan (SCAAIP) Accounting and Statistical Requirements Manual.

B. *Member Company* means every insurer authorized to write and engaged in writing automobile insurance in the State of South Carolina that was a participant in the South Carolina Associated Auto Insurers Plan (SCAAIP).

C. *South Carolina Associated Auto Insurers Plan or SCAAIP* means the joint underwriting association, established pursuant to South Carolina Act No. 154 of 1997, which was in effect from March 1, 1999 to February 28, 2003.

HISTORY: Added by State Register Volume 31, Issue No. 4, eff April 27, 2007.

69–62.3. Closeout and Termination of the SCAAIP

A. Purpose

The purpose of this regulation is to provide for the termination and orderly transfer of the business affairs and liabilities of the South Carolina Associated Auto Insurers Plan (SCAAIP) to the Associated Auto Insurers Plan of South Carolina.

B. Powers of the Advisory Board of the AAIP

Subject to the approval of the director or her designee, the Advisory Board of the AAIP shall develop policies and procedures for the orderly termination and wind-up of the affairs of the SCAAIP. The Advisory Board, on behalf of its members, is authorized to:

1) settle claims on policies issued by the SCAAIP.

2) establish procedures for the sharing among members of profit or loss on SCAAIP business and other costs, charges, expenses, liabilities, income, property and other assets of the SCAAIP. The assessments of members for their appropriate shares may be based on the member's premium volume or exposure units for business other than SCAAIP business or on a combination of such bases or on any other equitable basis.

3) reinsure SCAAIP business.

4) join, advise, assist, associate, cooperate and contract with its members and with such organizations, associations, insurers, governmental agencies, and others as may be necessary or proper to accomplish the transition of liabilities from the SCAAIP to the AAIP.

5) sue and be sued.

6) take any other action not specifically enumerated above or related thereto which is otherwise necessary or proper to accomplish the termination of the SCAAIP and the orderly transition and windup of its affairs.

C. Termination of the SCAAIP

Effective June 30, 2007, the SCAAIP shall terminate as a legal entity in South Carolina. Liability for any policy issued by the SCAAIP will be transferred to the AAIP of SC. The State of South Carolina shall have no liability or responsibility for any policy issued by the SCAAIP or AAIP of SC

D. Future SCAAIP Liabilities

Any future SCAAIP liability referenced above and a dollar amount equal to the case base reserves and IBNR shall be transferred to the AAIP of SC to be held in a termination fund. The AAIP will assume responsibility for the future settlement of any SCAAIP liability by utilization of these funds ("termination fund"). Should any future SCAAIP liability exceed the dollar amount available in the termination fund, the AAIP of SC may assess the AAIP membership in an amount to cover that liability and any future projected liability. This assessment will be handled in accordance with the procedure outlined in the AAIP of SC Plan of Operation and will be subject to the prior approval of Department of Insurance.

Any outstanding SCAAIP cash balance (prior membership assessments paid to cover SCAAIP underwriting results and its administrative expense) in excess of the termination fund will be reimbursed to the SCAAIP membership within 60 days of the issuance of the quarter ending June 30, 2007 SCAAIP Members Participation reports.

E. By February 28, 2014, the Advisory Board of the AAIP of SC will evaluate the outstanding liabilities of SCAAIP and determine how any remaining termination fund monies should be handled. The Advisory Board shall make a recommendation to the Director for approval. Should the Termination Fund remain in existence after 2014, the Advisory Board will evaluate the potential SCAAIP liability annually after that date until such time as the excess termination fund monies are fully distributed. The Advisory Board of the AAIP shall submit a filing requesting dissolution of the termination fund and the distribution of monies to the SCAAIP member companies to the Director of Insurance for prior approval once all liabilities of the SCAAIP have been settled.

HISTORY: Added by State Register Volume 31, Issue No. 4, eff April 27, 2007.

69–63. South Carolina Reinsurance Facility Recoupment.

A. Purpose

The purpose of this regulation is provided by South Carolina Code of Laws Section 38–77–530 that states in part:

"Beginning on March 1, 2002 and continuing thereafter, every insured or policyholder who does not have any insurance merit rating points pursuant to the Uniform Merit Rating Plan in effect upon the effective date of this act must not be surcharged for the recoupment of any facility assessments or losses; therefore, a clean or nonpointed risk shall no longer pay any form of recoupment seeking to recoup facility losses. Any surcharge as provided above during the period of March 1, 1999 through February 28, 2002 must be displayed as a part of the applicable premium charge for liability insurance coverage. However, beginning on March 1, 2002 every insured or policyholder who does have insurance merit rating points pursuant to the Uniform Merit Rating Plan in effect upon the effective date of this act shall be surcharged for the recoupment of any facility assessments or losses; therefore, these pointed risks shall be the only persons in the State of South Carolina who shall pay any recoupment fee for facility losses or assessments remaining in the facility on March 1, 2002 or any losses accruing in the facility after March 1, 2002. Furthermore, the director of the Department of Insurance shall promulgate a plan by regulation to recoup any losses remaining in the facility on March 1, 2002 or any losses accruing after March 1, 2002 only from those insureds or policyholders having insurance merit rating points as provided above. This plan shall include, but is not limited to, a schedule of recoupment and method of surcharge method whether a fixed fee, a percentage basis, or otherwise consider appropriate by the director."

B. Basis of Recoupment

Beginning on March 1, 2002 and continuing thereafter, a premium surcharge of 10% of liability premium shall be made on all drivers having points on March 1, 1999 on the basis of the merit rating plan in effect on March 1, 1999, as determined by convictions contained in the motor vehicle records.

C. Schedule of Recoupment

(1) Beginning on March 1, 2003 and each year thereafter, the director shall evaluate the funds collected by this surcharge and compare this amount with the projected runoff. The director may reduce the percentage surcharge from 10% to a lower amount or eliminate the surcharge completely by issuing a notice 120 days in advance to insurers that the director is considering reducing the percentage surcharge. The notice must include a 30 day period to allow comments from insurers. After the 30 day period has expired, the director may lower the surcharge by order.

(2) The director shall not lower the percentage surcharge unless the amount of recoupment projected to be recovered in the next fiscal year of the Reinsurance Facility is greater than the projected total remaining runoff of the South Carolina Reinsurance Facility. The collection of recoupment under this regulation must continue until the runoff obligations of the South Carolina Reinsurance Facility have been funded completely.

(3) In the event any recoupment fees are collected in excess of the ultimate Facility debt as determined upon a final Facility settlement and accounting, such excess funds must be forwarded to the South Carolina Department of Motor Vehicles for the enforcement of the uninsured motorist laws of South Carolina.

(4) The term "Ultimate Facility Debt" means the balance of all income and expense items for all open South Carolina Reinsurance Facility policy years and includes expenses incurred after the termination of the Facility, a final independent audit of the Facility, final disposition of all records and data as directed by the Board of Governors, and any other administrative and legal expenses that may be necessary to finalize the affairs of the Facility as determined by the Board of Governors or the South Carolina Department of Insurance.

HISTORY: Added by State Register Volume 25, Issue No. 6, eff June 22, 2001. Amended by State Register Volume 34, Issue No. 3, eff March 26, 2010.

69–64. Exempt Commercial Policies.

A. Purpose: The purpose of this regulation is to establish the definition of "exempt commercial policies" as provided by Section 38–1–20 (40) and referred to in Sections 38–73–340 and 38–73–520 and to explain the effect of the exemption.

B. Definition: "Exempt commercial policies" means all policies for commercial lines, as opposed to personal lines, insurance issued to commercial insureds, including all lines of commercial fire and

allied insurance, inland marine insurance, commercial multi-peril insurance, casualty insurance including workers' compensation insurance, fidelity insurance and commercial automobile insurance. Insurance related to credit transactions written through financial institutions is not included within the definition of "exempt commercial policies." Professional liability insurance for physician and health care providers is not included within the definition of "exempt commercial policies."

C. Effect of Exemption: No insurer of exempt commercial policies will be required to file any classification, rate, rule, or rating plan, or modifications thereof, for any exempt commercial insurance line prior to its use in this State. However, loss cost filings by an advisory or rating organization must still be filed for approval under Sections 38–73–340 and 38–73–520 prior to an insurer's use of the loss cost component of such filings. Rates for exempt commercial policies remain subject to the provisions of Sections 38–73–330 and 38–73–430. Section 37–73–910 and Section 38–73–920 are not applicable to exempt commercial policies.

In order to maintain credible data and to encourage safety in the workplace, every workers' compensation insurer must continue to adhere to the uniform classification system and uniform experience rating system or plan developed by the nonpartisan rating bureau for workers' compensation insurance under Section 38–73–510. Workers' compensation insurers, if utilizing special rates for "exempt commercial policies" in this State, are required to maintain a desk file of all rates so used and to exhibit the desk file to the Department upon request.

D. Exempt Commercial Policy Forms: In connection with an exempt commercial policy, an insurer may use any commercial insurance policy, contract, certificate or endorsement, including any form or endorsement developed by an advisory organization. If the form or endorsement has not been previously filed with the Department by an advisory organization or by the insurer, the insurer utilizing the form or endorsement must notify the Department of its use by mailing a copy of the form or endorsement to the Department as soon as practicable after the insurer begins using it. An insurer is required to maintain a desk file of all forms or endorsements used in connection with exempt commercial policies written in this State and to exhibit the desk file to the Department upon its request.

Any policy, contract, certificate or endorsement for use with exempt commercial policies in this State may be subsequently disapproved for continued use on a prospective basis by the Director or his designee upon a finding that the policy form or endorsement:

(1) does not meet the requirements of South Carolina law;

(2) contains any provisions which are unfair, deceptive, ambiguous, misleading or unfairly discriminatory; or

(3) is solicited by means of advertising communication or dissemination of information which is deceptive or misleading.

If a policy form or endorsement is determined not to be in compliance with the above requirements, the Director or his designee must issue an order specifying in detail how a specific provision(s) of the form or endorsement fails to meet the requirements and stating the date on which the form or endorsement can no longer be used. The Director's findings shall not affect policies in force prior to the date stated in the order. The insurer must thereafter, if required by the Director, submit to the Department a new policy form or endorsement, if any, replacing the discontinued form or endorsement.

HISTORY: Added by State Register Volume 27, Issue No. 6, Part 2, eff June 27, 2003.

69–65. Military Sales Practices.

Section 1. Purpose.

A. The purpose of this regulation is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Section 2. Scope.

This regulation shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States Armed Forces.

Section 3. Authority.

This regulation is issued under the authority of S.C. Code Ann. Section 38–57–10 *et seq.*

Section 4. Exemptions.

A. This regulation shall not apply to solicitations or sales involving:

(1) Credit insurance;

(2) Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;

(3) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Director of Insurance; or, when a term conversion privilege is exercised among corporate affiliates;

(4) Individual stand-alone health policies, including disability income policies;

(5) Contracts offered by Service members' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 *et seq.*;

(6) Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c) (23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

(7) Contracts used to fund:

(a) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

(c) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(e) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(f) Prearranged funeral contracts.

B. Nothing herein shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense DoD Instruction 1344.07—Personal Commercial Solicitation on DoD Installations or successor directive.

C. For purposes of this regulation, general advertisements, direct mail and internet marketing shall not constitute "solicitation." Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided however, nothing in this subsection shall be construed to exempt an insurer or insurance producer from this regulation in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in this subsection.

Section 5. Definitions.

A. "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

B. "Department of Defense (DoD) Personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

C. "Door to Door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

D. "General Advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

E. "Insurer" means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

F. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

G. "Known" or "Knowingly" means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited:

(1) is a service member; or

(2) is a service member with a pay grade of E-4 or below.

H. "Life Insurance" means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issued annuities.

I. "Military Installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

J. "MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

K. "Service Member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

L. "Side Fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(1) accumulated value or cash value or secondary guarantees provided by a universal life policy;

(2) cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(3) a premium deposit fund which:

(a) contains only premiums paid in advance which accumulate at interest;

(b) imposes no penalty for withdrawal;

(c) does not permit funding beyond future required premiums;

(d) is not marketed or intended as an investment; and

(e) does not carry a commission, either paid or calculated.

M. "Specific Appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.

N. "United States Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

Section 6. Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation

A. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

(1) Knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

(2) Soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.

(3) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(4) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

(5) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(6) Posting unauthorized bulletins, notices or advertisements.

(7) Failing to present DD Form 2885, *Personal Commercial Solicitation Evaluation*, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(8) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

B. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(2) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

Section 7. Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location.

A. The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's "MyPay" account or other similar internet or electronic medium for such purposes. This subsection does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

(2) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(a) provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 *et seq.* and the regulations promulgated thereunder; and

(b) permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(3) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in subsection 7 (A)(2).

(4) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

(5) Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

(6) Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

(7) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

(8) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

B. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

(1) Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor." Nothing herein shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science in Financial Services (MSFS), or Masters of Science Financial Planning (MS).

(2) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

C. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

(1) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(2) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free."

D. The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

(1) Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.

(2) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive.

(3) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the

replacement shall take effect upon or after the service member's separation from the United States Armed Forces.

E. The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

(1) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

(2) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.

(3) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.

(4) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the "Military Personnel Financial Services Protection Act," Pub. L. No. 109–290, p.16.

(5) Excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

(a) an explanation of any free look period with instructions on how to cancel if a policy is issued; and

(b) either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of Regulation 69–40, Life Insurance Policy Illustration Rules, shall be deemed sufficient to meet this requirement for a written disclosure.

F. The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

(1) Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

(2) Offering for sale or selling a life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(a) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.

(b) "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

(3) Excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund:

(a) unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(b) unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations

and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

(c) which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.

(4) Excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

(5) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage, *e.g.*, double indemnity, which may be excluded.

Section 8. Severability.

If any provision of these sections or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of these sections are declared to be severable.

Section 9. Effective Date.

This regulation shall become effective upon date of final publication in the *South Carolina State Register* and shall apply to acts or practices committed on or after that date.

HISTORY: Added by State Register Volume 31, Issue No. 11, eff November 23, 2007.

69–70. Annual Audited Financial Reporting Regulation.

(Statutory Authority: S.C. Code Sections 1–23–110, 38–3–110, 38–13–80, 38–90–150, and 38–90–630)

Section 1. Authority

This regulation is promulgated by the Director of Insurance (Director) of the South Carolina Department of Insurance (Department) pursuant to Sections 38–3–110, 38–13–80, 38–90–150 and 38–90–630 of the South Carolina Code of Laws.

Section 2. Purpose and Scope

A. The purpose of this regulation is to improve the Department's surveillance of the financial condition of insurers, as defined in Section 3, by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management's Report of Internal Control over Financial Reporting.

B. Every insurer shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the Director makes a specific finding that compliance is necessary for the Director to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt. For purposes of this subsection, all premiums written or assumed by a captive insurer shall be deemed to be written in this state.

C. Foreign or alien insurers filing the Audited Financial Report in another state, pursuant to that state's requirement for filing of Audited Financial Reports, which has been found by the Director to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

(1) A copy of the Audited Financial Report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the Director in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

(2) A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Director within the time specified in Section 10.

D. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

E. This regulation shall not prohibit, preclude or in any way limit the Director from ordering or conducting or performing examinations of insurers under the rules and regulations of the Department and the practices and procedures of the Department.

F.(1) Except as otherwise provided in this subsection, this regulation shall not apply to captive insurance companies other than captive insurers as defined in Section 3(A)(5). In the case of a conflict between a provision of Regulation 69–60 and a provision of this regulation, the latter controls.

(2) The Director may, by written notice, require a captive insurance company that is not otherwise subject to this regulation to comply with any provision or requirement of this regulation by making a specific finding that compliance is necessary for the Director to carry out statutory responsibilities. In arriving at this finding, the Director may consider the captive insurance company's business plan, including the nature of the risks insured, and other factors the Director considers advisable. Such a notice may be issued at any time and from time to time for a specified period or periods. Within thirty days from issuance of the notice, the captive insurance company may request in writing a hearing, pursuant to statute, on the requirement for compliance. The hearing shall be held in accordance with South Carolina law pertaining to administrative hearing procedures.

(3) Notwithstanding any provision of this regulation to the contrary, a captive insurance company made subject to this regulation by written notice pursuant to Section 2(F)(2) shall file its Audited Financial Report on or before the date that is six months following the last day of the captive insurance company's fiscal year end, provided that the Director may require an earlier filing than such date with ninety days advance notice to the captive insurance company. Extensions of the filing date may be granted by the Director for thirty-day periods upon a showing by the captive insurance company and its independent certified public accountant of the reasons for requesting an extension and determination by the Director of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the Director to make an informed decision with respect to the requested extension. If an extension of the filing date is granted, a similar extension of thirty days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

(4) Every captive insurance company required to file an annual Audited Financial Report by written notice pursuant to Section 2(F)(2) shall designate a group of individuals as constituting its Audit Committee, as defined in Section 3(A)(3). The Audit Committee of an entity that controls the captive insurance company may be deemed to be the captive insurance company's Audit Committee for purposes of this regulation at the election of the controlling person.

Section 3. Definitions

A. The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(2) "Affiliate" of a specific person or a person "affiliated" with a specific person means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the specific person.

(3) "Audit Committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the Internal audit function of an insurer or group of insurers (if applicable), and external audits of financial statements of the insurer or group of insurers. The Audit Committee of any entity that controls a group of insurers may be deemed to be the Audit Committee for one or more of these controlled insurers solely for the purposes of this regulation at the election

of the controlling person. Refer to Section 14(A)(5) for exercising this election. If an Audit Committee is not designated by the insurer, the insurer's entire board of directors shall constitute the Audit Committee.

(4) "Audited Financial Report" means and includes those items specified in Section 5 of this regulation.

(5) "Captive insurer" means any captive insurance company licensed as a risk retention group, South Carolina coastal captive insurance company, special purpose financial captive, or other captive insurance company made subject to this regulation by written notice pursuant to Section 2(F)(2).

(6) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(7) "Independent board member" has the same meaning as described in Section 14(A)(3).

(8) "Insurer" includes any captive insurer as defined in Section 3(A)(5), health maintenance organization, title insurer, fraternal organization, burial association, other association, corporation, partnership, society, order, individual, or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance or surety business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.

(9) "Group of insurers" means those licensed insurers included in the reporting requirements of Title 38, Chapter 21 - Insurance Holding Company Regulatory Act, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(10) "Internal audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

(11) "Internal control over financial reporting" means a process effected by an insurer's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and includes those policies and procedures that:

(a) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(b) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(c) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation.

(12) "SEC" means the United States Securities and Exchange Commission.

(13) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.) and the SEC's rules and regulations promulgated thereunder.

(14) "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3(A)(1).

(15) "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.): (i) the pre-approval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934) (15 USC Section 78a et seq.)); (ii) the Audit Committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934 (15 USC Section 78a et seq.)); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an Audited Financial Report with the Director on or before June 1 for the year ended December 31 immediately preceding. The Director may require an insurer to file an Audited Financial Report earlier than June 1 with ninety days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the Director for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Director of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the Director to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in Section 4(B), a similar extension of thirty days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual Audited Financial Report pursuant to this regulation shall designate a group of individuals as constituting its Audit Committee, as defined in Section 3. The Audit Committee of an entity that controls an insurer may be deemed to be the insurer's Audit Committee for purposes of this regulation at the election of the controlling person.

E. This section does not apply to a captive insurance company made subject to this regulation by written notice pursuant to Section 2(F)(2). Such a captive insurance company shall comply with the requirements of Section 2(F)(3) and 2(F)(4).

Section 5. Contents of Annual Audited Financial Report

A. The annual Audited Financial Report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flow, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the insurer's state of domicile.

B. The annual Audited Financial Report shall include the following:

(1) Report of independent certified public accountant;

(2) Balance sheet reporting admitted assets, liabilities, capital and surplus;

(3) Statement of operations;

(4) Statement of cash flow;

(5) Statement of changes in capital and surplus;

(6) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 38–13–80 of the South Carolina Code of Laws with a written description of the nature of these differences;

(7) The financial statements included in the Audited Financial Report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Director, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an Audited Financial Report, the comparative data may be omitted.

Section 6. Designation of Independent Certified Public Accountant

A. Each insurer required by this regulation to file an annual Audited Financial Report, within sixty days after becoming subject to the requirement, shall register with the Director in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first Audited Financial Report is to be filed.

B. The insurer shall obtain a letter from the accountant and file a copy with the Director stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the accountant may believe appropriate.

C. If the accountant who was the insurer's accountant for the immediately preceding filed Audited Financial Report is dismissed or resigns, the insurer shall notify the Director within five business days of this event. The insurer shall also furnish the Director with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding the event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this section include those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer also in writing shall request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish the responsive letter from the former accountant to the Director together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

A. The Director shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

B. Except as otherwise provided in this regulation, the Director shall recognize an independent certified public accountant as qualified as long as the accountant conforms to the standards of the profession, as contained in the AICPA Code of Professional Conduct and the regulations of the South Carolina Board of Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 27 of Title 38 of the South Carolina Code of Laws, the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same insurer or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the Director for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty days before the end of the calendar year. The Director may consider the following factors in determining if the relief should be granted:

(1) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(2) Premium volume of the insurer; or

(3) Number of jurisdictions in which the insurer transacts business.

E. The insurer shall file, with its annual statement filing, the approval for relief from Subsection D with the states that it is licensed in or doing business in and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. A captive insurer is not required to file the approval for relief from Subsection D with the NAIC if the captive insurer is not required to file its annual statement with the NAIC.

F. The Director shall not recognize as a qualified independent certified public accountant or accept any annual Audited Financial Report prepared in whole or in part by any person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Section 1961 et seq., or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

G. The Director, pursuant to statute, may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited Financial Report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

H. The Director shall not recognize as a qualified independent certified public accountant or accept an annual Audited Financial Report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(1) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) Financial information systems design and implementation;

(3) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(4) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification (''opinion'') on an insurer's reserves if the following conditions have been met:

(a) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(b) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(c) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(5) Internal audit outsourcing services;

(6) Management functions or human resources;

(7) Broker or dealer, investment adviser, or investment banking services;

(8) Legal services or expert services unrelated to the audit; or

(9) Any other services that the Director determines, by regulation, are impermissible.

I. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit their own work, and cannot serve in an advocacy role for the insurer.

J. Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection H. The insurer shall file with the Director a written statement discussing the reasons why the insurer should be exempt from these provisions. An exemption may be granted if the Director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer.

K. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection H or that do not conflict with Subsection I, only if the activity is approved in advance by the Audit Committee, in accordance with Subsection L.

L. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be pre-approved by the Audit Committee. The pre-approval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the Audit Committee and approved prior to the completion of the audit by the Audit Committee or by one or more members of the Audit Committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit Committee.

M. The Audit Committee may delegate to one or more designated members of the Audit Committee the authority to grant the pre-approvals required by Subsection L. The decisions of any member to whom this authority is delegated shall be presented to the full Audit Committee at each of its scheduled meetings.

N. The Director shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the Director for relief from the above requirement on the basis of unusual circumstances.

O. The insurer shall file, with its annual statement filing, the Director's letter granting relief from Subsection N with the states in which it is licensed or doing business and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. A captive insurer is not required to file the Director's letter granting relief from Subsection N with the NAIC if the captive insurer is not required to file its annual statement with the NAIC.

Section 8. Consolidated or Combined Audits

A. An insurer may make written application to the Director for approval to include in its Audited Financial Report audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined Audited Financial Report shall be shown on the worksheet;

(2) Amounts for each insurer subject to this section shall be stated separately;

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis;

(4) Explanations of consolidating and eliminating entries shall be included; and

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual Statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with Auditing (AU) Section 319 of the AICPA

Professional Standards, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 17, the independent certified public accountant should consider (as that term is defined in Statements on Auditing Standards (SAS) No. 102 of the AICPA Professional Standards, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual Audited Financial Report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its Audit Committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Director as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the South Carolina Code of Laws as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the Director within five business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Director. If the independent certified public accountant fails to receive the evidence within the required five business day period, the independent certified public accountant shall furnish to the Director a copy of its report within the next five business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.

C. If the accountant, subsequent to the date of the Audited Financial Report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the Director notes the obligation of the accountant to take such action as prescribed in AU 561 of the AICPA Professional Standards, Subsequent Discovery of Facts Existing at the Date of the Auditor's Report.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual Audited Financial Report, each insurer shall furnish the Director with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty days after the filing of the annual Audited Financial Report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined in SAS No. 112 of the AICPA Professional Standards, Communicating Internal Control Related Matters Identified in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the Audited Financial Report discussed in Section 4(A)) in the insurer's Internal control over financial reporting identified by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

C. The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. The information should be made available to the examiner conducting a financial examination for review and kept in a manner as to remain confidential.

Section 12. Accountant's Letter of Qualifications

A. The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual Audited Financial Report, a letter stating:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of their profession as contained in the AICPA's Code of Professional Conduct and pronouncements

of its Financial Accounting Standards Board and the South Carolina Board of Accountancy, or similar code;

(2) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(3) That the accountant understands the annual Audited Financial Report and that its opinion thereon will be filed in compliance with this regulation and that the Director will be relying on this information in the monitoring and regulation of the financial position of insurers;

(4) That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the Director, or the Director's designee or appointed agent, the workpapers, as defined in Section 13;

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

(6) A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Workpapers

A. Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of insurer documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

B. Every insurer required to file an Audited Financial Report pursuant to this regulation, shall require the accountant to make available for review by Department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department or at any other reasonable place designated by the Director. The insurer shall require that the accountant retain the audit workpapers and communications until the Department has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the Department.

Section 14. Requirements for Audit Committees

A. This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

(1) The Audit Committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited Financial Report or related work pursuant to this regulation. Each accountant shall report directly to the Audit Committee.

(2) The Audit committee of an insurer or Group of insurers shall be responsible for overseeing the insurer's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this Regulation.

(3) Each member of the Audit Committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection (A)(6) of this Section and Section 3(A)(3).

(4) In order to be considered independent for purposes of this section, a member of the Audit Committee may not, other than in his or her capacity as a member of the Audit Committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit Committee and be designated as independent for Audit Committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(5) If a member of the Audit Committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Director, may remain an Audit Committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(6) To exercise the election of the controlling person to designate the Audit Committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Director by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(7) The Audit Committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit Committee in accordance with the requirements of SAS No. 114 of the AICPA Professional Standards, The Auditor's Communication with those Charged with Governance, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(8) If an insurer is a member of an insurance holding company system, the reports required by Subsection (A)(7) may be provided to the Audit Committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit Committee.

(9) The proportion of independent Audit Committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0-$300,000,000	Over $300,000,000 - $500,000,000	Over $500,000,000
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The Director has authority afforded by state law to require the insurer's board to enact improvements to the independence of the Audit Committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit Committees with at least a supermajority of independent Audit Committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(10) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may

make application to the Director for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Internal Audit Function Requirements

A. Exemption - An insurer is exempt from the requirements of this section if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(2) If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

B. Function - The Insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

C. Independence - In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting - The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements - If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

Section 16. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Director, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's Audit Committee.

Section 17. Management's Report of Internal Control over Financial Reporting

A. Each insurer required to file an Audited Financial Report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' Internal Control Over Financial Reporting, as these terms are defined in Section 3. The report shall be filed with the Director along with the Communicating Internal Control Related Matters Identified in an Audit described under Section 11. Management's Report of Internal Control Over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in Subsection A, the Director may require an insurer to file Management's Report of Internal Control Over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in S.C. Code Ann. Sections 35–5–120, 38–9–150, 38–9–360, and 38–9–440.

C. An insurer or a group of insurers that is

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX compliant entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity; may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section 17 requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 17 report, or (ii) the Section 404 Report and a Section 17 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control Over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by Subsection A, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Director.

Section 18. Exemptions

A. Upon written application of an insurer, the Director may grant an exemption from compliance with any provision or requirement of this regulation if the Director finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing, pursuant to statute, on its application for an exemption. The hearing shall be held in accordance with South Carolina law pertaining to administrative hearing procedures.

B. Domestic insurers retaining a certified public accountant on the effective date of this regulation shall comply with this regulation for the year ending December 31, 2019 and each year thereafter unless the director permits otherwise

C. Domestic insurers retaining

If an insurer or Group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

Section 19. Canadian and British Companies

A. For Canadian and British insurers, the annual Audited Financial Report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited Financial Report filed with the Director pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 20. Effective Dates

A. Unless otherwise noted, the requirements of this regulation shall become effective for the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers not required to file a report because its total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file the report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or combination to comply with the reporting requirements.

B. The requirements of Section 7D shall become effective for audits of the year beginning January 1, 2010 and thereafter.

C. The requirements of Section 14 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent Audit Committee members or only a majority of independent Audit Committee members (as opposed to a supermajority) because the total direct written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one calendar year following the date of acquisition or combination to comply with the independence requirements.

Section 21. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

HISTORY: Added by State Register Volume 33, Issue No. 5, eff May 22, 2009. Amended by State Register Volume 34, Issue No. 5, eff May 28, 2010; SCSR 43–5 Doc. No. 4835, eff May 24, 2019.

69–75. Tax Credits for Fortification Measures.

Section 1. Purpose and Qualifying Fortification Measures

A. The purpose of this regulation is to set forth the fortification measures that qualify for the state income tax credit allowed pursuant to Section 12–6–3660.

B. An individual taxpayer is allowed a state income tax credit for costs incurred to implement the fortification measures outlined in this regulation. The fortification measures must be made to a structure qualifying as the taxpayer's legal residence pursuant to Section 12-43-220(c). The tax credit allowed pursuant to Section 12–6–3660 for any taxable year must not exceed the lesser of:

(1) twenty-five percent of the cost incurred; or

(2) one thousand dollars for a qualifying residence regardless of the number of taxpayers residing in the residence.

C. The standards which must be met by an individual taxpayer to qualify for state income tax credits for costs to fortify the taxpayer's legal residence pursuant to S.C. Code Section 12–6–3660 or sales and use tax credits pursuant to S.C. Code Section 12–6–3665 are the same as those required under the SC Safe Home Program that are contained in the *South Carolina Safe Home Resource Document for Mitigation Techniques* dated July 2008, developed for the SC Safe Home Program by the Federal Alliance for Safe Homes and available at www.scsafehome.com. That document is incorporated herein by reference and available on the Department's website. Fortification measures must be accomplished in accordance with the standards contained in the *South Carolina Safe Home Resource Document for Mitigation Techniques*. All products must have an ICC Evaluation Services Legacy Report or other appropriate test reports acceptable to the local building officials for the intended use.

The South Carolina Department of Insurance must review and update the manual as necessary to comply with changes in building code standards, mitigation measures or other applicable provisions of state or federal law.

Section 2. Evidence

A. To qualify for the tax credit, the individual taxpayer must maintain evidence that the fortification measures were implemented and costs incurred. Evidence necessary to prove the taxpayer is entitled to the credit must be provided to the Department of Revenue upon request.

B. The acceptable forms of evidence include:

(1) A written certification or a report (with certification) from a licensed professional with expertise in construction techniques, building design or property inspection or appraisal including, but not limited to an: architect; appraiser; building inspector; or contractor that the fortification measure has been implemented in accordance with applicable standards. Copies of the applicable receipts must accompany the certification or report; or

(2) An Affidavit from the individual taxpayer certifying that the fortification measures have been implemented. Copies of the applicable receipts must accompany the affidavit.

HISTORY: Added by State Register Volume 33, Issue No. 6, eff June 26, 2009.

69–76. SC Safe Home Program Wind Inspectors and Contractors.

Section I. Purpose and Scope

The purpose of this regulation is to specify requirements and qualifications for wind inspectors and contractors participating in the SC Safe Home Program.

Section II. Wind Inspectors

A. In order to obtain certification from the Department of Insurance as a wind inspector for the SC Safe Home Program, an individual must:

(1) submit an application on a form approved by the Department;

(2) take the Federal Alliance for Safe Homes (FLASH) *Blueprint for Safety* Course, or other similar course approved by the Department, and pass the inspector's examination with a grade of 90% or higher; and

(3) have a demonstrated working knowledge of residential building practices through:

(a) being actively licensed by and in good standing with the South Carolina Labor Licensing and Regulation Division as a general contractor or residential builder; or

(b) if not required to be licensed, documentation of five years experience working in the residential construction industry.

B. Certified wind inspectors must attend an annual meeting of wind inspectors or other program of continuing education at a date, time and location set by the SC Safe Home Advisory Committee.

Section III. Contractors

A. In order to obtain certification from the Department of Insurance as a contractor for the SC Safe Home Program, an individual must:

(1) submit an application on a form approved by the Department;

(2) be actively licensed and in good standing through the offices of the South Carolina Labor Licensing and Regulation Division as a general contractor or residential builder; and

(3) take the Federal Alliance for Safe Homes (FLASH) *Blueprint for Safety* Course, or other similar course approved by the Department, and pass the contractor's examination with a grade of 90% or higher.

B. Certified contractors must attend an annual meeting of contractors or other program of continuing education at a date, time and location set by the SC Safe Home Advisory Committee.

Section IV. Citizenship Requirements for Wind Inspectors and Contractors

Only natural persons may be certified as wind inspectors and contractors to work with the SC Safe Home Program. The applicant shall be a citizen of the United States or provide documentation that the applicant is a properly registered alien residing in the United States.

Section V. Absence of Criminal Record

In determining whether an individual is eligible to be certified as a wind inspector or contractor to work with the SC Safe Home Program, the director or his designee must, among other things, consider whether the individual has been convicted of, or pleaded guilty or nolo contendere to, a crime involving moral turpitude. To satisfy the director or his designee that an individual is trustworthy and has not been convicted of a crime involving moral turpitude, the individual applicant must, as part of their application, obtain from the South Carolina State Law Enforcement Division (SLED) a copy of the applicant's criminal history record. Such copy of the applicant's criminal history record must be filed with the Department along with the applicant's application for certification.

Section VI. Requirements Relating to Probation, Withdrawal or Suspension of a Certification, Refusal to Issue a Certification and Reissuance of a Certification

A. Recommendations of the SC Safe Home Advisory Committee

(1) The SC Safe Home Advisory Committee may, upon a majority vote, recommend to the Department probation, withdrawal, or suspension of the certification of any wind inspector or contractor. Such recommendation must be submitted to the director or his designee in writing, specifying the recommended action to be taken and the findings of the Advisory Committee in reaching the recommendation. Recommendations for probation must specify a length of time, not

to exceed one year, for which the Advisory Committee recommends the probation. The Advisory Committee may, among other things, consider misconduct or any fraudulent or deceitful action or inaction by the certified wind inspector or certified contractor in the performance of his or her duties as a certified wind inspector or certified contractor.

(2) A person who alleges incompetence, misconduct, fraud, or deceit against a certified wind inspector or certified contractor must submit such allegations in writing to the Department. Upon receipt, the Department may provide a copy of the written allegation to the Advisory Committee and request that the Advisory Committee review the allegation and submit a recommendation pursuant to item (1) of this subsection.

B. Procedure for probation, withdrawal, or suspension of a certification or refusal to issue a certification

(1)(a) The director or his designee may place on probation, withdraw, or suspend a wind inspector's or contractor's certification after ten days' notice or refuse to issue a certification when it appears that a wind inspector or contractor or applicant for certification has been convicted of a crime involving moral turpitude, has violated this regulation, or has willfully deceived or dealt unjustly with the citizens of this State.

(b) The words "deceived or dealt unjustly with the citizens of this State" include, but are not limited to, action or inaction by the wind inspector or contractor as follows:

(i) providing incorrect, misleading, incomplete, or materially untrue information in the application for certification;

(ii) obtaining or attempting to obtain a certification through misrepresentation or fraud;

(iii) improperly withholding, misappropriating, or converting any monies or properties received in the course of doing business as a certified wind inspector or certified contractor;

(iv) having been convicted of a felony;

(v) using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere;

(vi) forging another's name to an application for a SC Safe Home grant application or to any document related to the SC Safe Home Program; and

(vii) improperly using notes or any other reference material to complete an examination relating to certification as a wind inspector or contractor.

(2) The director or his designee must also consider whether the individual has had a license or its equivalent, to operate as a general contractor or residential builder denied, suspended, or revoked in this state or another state, province, district, or territory.

C.(1) If upon investigation the director or his designee finds that a wind inspector or contractor has obtained a certification by fraud or misrepresentation, he may suspend immediately the certification. The director or his designee, in an order suspending a certification shall specify the period during which the suspension is to be in effect. The period may not exceed one year.

(2) In addition to or in lieu of any applicable denial, probation, suspension, or revocation of a certification a person violating this regulation may, after a hearing, be subject to an administrative penalty according to Section 38–2–10.

D. Procedures relating to the reissuance of a withdrawn certification or issuance of a certification to an applicant who has been refused a certification.

(1)(a) A contractor or wind inspector whose certification is withdrawn or an applicant who has been refused a certification by the director or his designee may not reapply for certification until a six-month period of time has lapsed from the effective date of the withdrawal or refusal or, if judicial review before the Administrative Law Court of the withdrawal or refusal is sought, after six months from the date of a final court order or decree affirming the withdrawal or refusal.

(b) In the case of the director or his designee's refusal to issue a certification on an application submitted pursuant to subitem (a), the applicant may reapply for certification, not to exceed three times, after the exhaustion of a six-month period of time from the effective date of the refusal or, if judicial review before the Administrative Law Court of the refusal is sought, after six months from the date of a final court order or decree affirming the refusal.

(2) An individual submitting an application pursuant to item (1) of this subsection must comply with all certification requirements set forth this regulation

E. Notice of the director or his designee's probation, withdrawal, or suspension of a certification or refusal to issue a certification must be provided in writing and mailed to the last known address of the certified individual or applicant via US Certified Mail/Return Receipt Requested. The written notice must advise the applicant or certified individual of the reason for the probation, withdrawal, or suspension of the certification or the refusal to issue the certification. The applicant or certified individual may make written demand upon the Administrative Law Judge within thirty days of the date of receipt of the notice for a hearing before the Administrative Law Court to determine the reasonableness of the director or his designee's action. The hearing must be held pursuant to the Administrative Procedures Act.

Section VII. Effective Date

The regulation will become effective upon final publication in the South Carolina *State Register*.

HISTORY: State Register Volume 35, Issue No. 5, eff May 27, 2011.

69–77. Pharmacy Benefits Managers.

(Statutory Authority: 1976 Code Sections 1–23–110, 38–3–110, and 38–71–2200 et seq.)

Section I. Purpose

The purpose of this regulation is to implement Act No. 48 of 2019 ("the Act") regarding pharmacy benefits managers and to provide licensing, reporting and activity standards for pharmacy benefits managers.

Section II. Licensure Requirements

A. Initial License and Renewal. On or after January 1, 2021, a pharmacy benefits manager shall apply for a license on a form and in accordance with a licensing schedule prescribed by the Director or his designee. The terms "Director" and "designee" have the meaning set forth in Section 38–1–20 of the Code of Laws of South Carolina 1976, as amended.

B. The initial licensing schedule shall be set by bulletin or order of the Director. In 2022, and thereafter, a pharmacy benefits manager license shall be renewed annually no later than March 1 of each year.

C. Each application for a license shall be certified by an officer or authorized representative of the applicant and shall contain a statement that certifies the pharmacy benefits manager is in compliance with Section 38–71–2220 of the Code of Laws of South Carolina 1976, as amended. All proprietary information submitted by the pharmacy benefits manager under Section II of this regulation shall be considered confidential under Sections 38–71–2250 and 30–4–40 of the Code of Laws of South Carolina 1976, as amended.

D. The pharmacy benefits manager shall provide as part of the application for licensure the following:

(1) A non-refundable filing fee of $1,000 for initial licensure and $500 for renewal licenses;

(2) A copy of the basic organizational document of the pharmacy benefits manager, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto;

(3) a copy of the bylaws, organizational or similar document(s), if any, regulating the conduct or the internal affairs of the applicant;

(4) A copy of the pharmacy benefits manager's provider manual and written agreement(s), excluding pricing information, but including audit procedures, which it uses for contracts entered into with pharmacists, pharmacies or pharmacy services administrative organizations in administration of pharmacy benefits for health care insurers in this State or a representative written agreement and provider manual, excluding pricing information, but including audit procedures, for each type of network provider, which it uses for contracts entered into with pharmacists, pharmacies or pharmacy services administrative organizations in administration of pharmacy benefits for health care insurers in this State;

(5) For the two preceding calendar years, a listing of health care insurers with which the pharmacy benefits manager was contracted in this State to perform claims processing services and the number of enrollees or beneficiaries covered by each health care insurer;

(6) The relevant documentation, such as a policies and procedures manual, that demonstrates the pharmacy benefits manager has adopted processes to ensure compliance with the requirements in Section 38–71–2240 of the Code of Laws of South Carolina 1976, as amended, including any written policies or procedures describing the appeals dispute resolution process for in-network or contracted pharmacists or pharmacies;

(7) A certified statement that indicates whether the applicant or officer with management or control:

(a) has been refused or denied a registration, license or certification to act as or provide the services of a pharmacy benefits manager or third-party administrator in any state, providing specific details separately for each such refusal or denial, if any, including the date, nature and disposition of the action; and

(b) has had any registration, license or certification to act as such suspended, revoked or nonrenewed for any reason by any state or federal entity, providing specific details separately for each such suspension, revocation or nonrenewal, if any, including the date, nature and disposition of the action, and attaching a copy of any relevant final order or similar document imposing the suspension, revocation or nonrenewal;

(8) A description of whether the applicant has had a business relationship with an insurer terminated for any fraudulent or illegal activities in connection with the administration of a pharmacy benefits plan (if so, attach specific details separately explaining this termination, including the date, and nature of the termination); and

(9) Any other relevant information deemed necessary by the Director or his designee to evaluate the application for licensure or compliance with the requirements of the Act and this regulation.

E. Review Process

(1) Initial and Renewal License Applications

For initial and renewal license applications, the Director or his designee shall review the application under Section II.D of this regulation, and may:

(a) approve the application and issue the applicant a pharmacy benefits manager license; or

(b) notify the applicant, in writing, that the application is incomplete and request additional information to complete the review; and, if the missing or requested information is not received within thirty (30) days from the date of the notification, the Director or his designee may deny the application; or

(c) deny the application; and

(i) provide written notice to the applicant that the application has been denied stating or explaining the basis of the denial; and

(ii) advise the applicant that it may appeal the denial by requesting a hearing in accordance with Section 38–3–210 of the Code of Laws of South Carolina 1976, as amended, before the South Carolina Administrative Law Court.

(2) Standards of Review

(a) The Director or his designee shall deny an initial or renewal application for licensure for the following reasons:

(i) the pharmacy benefits manager operates, or proposes to operate, in a hazardous condition and the services it administers, or proposes to administer, for health care insurers in this State may be hazardous to the insurance-buying public; or

(ii) the pharmacy benefits manager has violated the requirements of the Act, this regulation or other applicable South Carolina law; or

(iii) the pharmacy benefits manager has failed to timely submit information to complete review of the application under Section II of this regulation.

(b) In lieu of a denial of a renewal application, the Director or his designee may permit the pharmacy benefits manager to submit to the Director or his designee a corrective action plan to cure or correct deficiencies falling under Section II of this regulation, impose an administrative penalty under Section 38–2–10 et seq. of the Code of Laws of South Carolina, 1976 as amended, or both.

Section III. Contract Review

A. Contract Review

(1) Prohibited Contract Language

No contract entered into by a pharmacy benefits manager and a pharmacist or pharmacy which relates to participation or administration of a pharmacy benefits plan or program of a health care insurer shall contain language in violation of the Sections 38–71–2200 *et seq* of the Code of Laws of South Carolina 1976, as amended or other applicable provision of South Carolina law.

(2) Waiver Prohibited

The prohibitions set forth Sections 38–71–2220 *et seq* of the Code of Laws of South Carolina 1976, as amended cannot be waived by contract.

B. Marketing and Advertising

Pursuant to Section 38–71–2230, a pharmacy benefits manager shall not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading. The Department does not review or otherwise pre-approve marketing materials prior to their use. It is the responsibility of the pharmacy benefits manager to ensure that its marketing materials comply with the laws of the State of South Carolina.

Section IV. Examinations

A. Examination of Pharmacy Benefits Managers.

(1) Pursuant to Section 38–71–2250 of the Code of Laws of South Carolina 1976, as amended, the Director or his designee may examine the affairs of a pharmacy benefits manager for compliance with the requirements of the Act, applicable South Carolina law or requirements of this regulation.

(2) Any examination permitted under this Section shall follow the examination procedures and requirements applicable to health care insurers under Chapter 13, Title 38 of the Code of Laws of South Carolina 1976, as amended.

B. A pharmacy benefits manager shall not be regularly examined under the same time periods as insurers as required under Section 38–13–10 of the Code of Laws of South Carolina 1976, as amended, however, the Director or his designee may examine the pharmacy benefits manager pursuant to Section 38–71–2250 at any time he or she believes it reasonably necessary to ensure compliance with the Act, the provisions of this regulation, or Title 38.

Section V. Record Keeping Requirements

A. Maximum Allowable Costs

In order to facilitate any examination conducted by the Director pursuant to Section IV of this regulation, pharmacy benefits managers shall maintain a record keeping system which shall track and monitor the following statistical information:

(1) the number of challenges or appeals the pharmacy benefits manager received under the maximum allowable cost provisions of the Act;

(2) the outcomes of each of those challenges or appeals, whether denied or upheld by the pharmacy benefits manager, and sufficient information to determine compliance with Section 38–71–2240. This information must include the following:

(i) notice to the challenging pharmacy of the appeal results and the information required by Section 38–71–2240; and

(ii) documentation of any changes made for similarly situated pharmacies as outlined in the Act.

B. A request under this Subsection shall be considered a special report pursuant to Section 38–13–160 of the South Carolina Code of Laws 1976, as amended, and all information submitted in the response shall be confidential. The requirements of this Subsection shall apply for appeals or challenges beginning with the first quarter of 2021.

C. Pharmacy Provider Complaints Related to Maximum Allowable Cost List Compliance under Section 38–71–2240 of the Code of Laws of South Carolina 1976, as amended.

(1) The pharmacy benefits manager shall designate the name, address, and phone number, including an electronic mail contact, of the organization which shall be responsible for responding to the Department for complaints the Department has received from pharmacy providers for alleged Maximum Allowable Cost List violations. The pharmacy benefits manager shall be subject to Section 38–13–70 of the Code of Laws of South Carolina 1976, as amended related to the time period for a response to the Department.

(2) A pharmacy provider or other person acting on its behalf shall make reasonable efforts to exhaust any internal appeal requirements of the pharmacy benefits manager prior to the filing of a complaint with the Department. However, a pharmacy provider shall not be required to exhaust internal appeal requirements of the pharmacy benefits manager if a pharmacy benefits manager has failed to abide by its Maximum Allowable Cost List appeal processes as described in Section 38–71–2240. A pharmacy benefits manager shall not be held responsible for failure to provide communication or timely processing in the event that a provider or pharmacy has not submitted sufficient information for the pharmacy benefits manager to process the appeal.

(3) The Department shall review the complaints, and upon determination of a violation of the Act or this regulation, institute regulatory action in accordance with the requirements set forth in Section VIII of this regulation.

(4) The Department may refer any complaints to the Office of the South Carolina Attorney General for investigation or other enforcement action in accordance with Section 38–3–110 of the Code of Laws of South Carolina 1976, as amended.

Section VI. Confidentiality

The Department may report on its activities relating to the implementation of the Act and this regulation in compliance with the confidentiality requirements set forth in the Act and this regulation.

Section VII. Transition of Licensing Status

A. The Director or his designee shall publish by order or bulletin the plan and timeframe for transitioning licenses from the third-party administrator license to the pharmacy benefits manager license.

B. Pharmacy benefits managers engaged exclusively or solely with administration of pharmacy benefits of self-funded health benefit plans in this State shall comply with the registration requirements of Chapter 51 of Title 38 of the Code of Laws of South Carolina 1976, as amended. For pharmacy benefits managers engaged in the administration of pharmacy benefits for both fully insured health benefits plans and self-funded health plans, a pharmacy benefits manager must comply with the Act and this regulation with respect to the provisions that apply to its fully insured health benefits plans.

Section VIII. Penalties

Violations of this regulation shall be subject to the penalties set forth in Section 38–2–10 through 38–2–30 of the Code of Laws of South Carolina 1976, as amended.

Section IX. Severability

Any section or provision of this regulation held by a court to be invalid or unconstitutional shall be considered severable and will not affect the validity of any other section or provision of this regulation.

Section X. Conflict

If any provision of this regulation is inconsistent with the Act, the provisions of the Act control.

HISTORY: Added by SCSR 44–6 Doc. No. 4932, eff June 26, 2020.

69–80. Corporate Governance Annual Disclosure Regulation.

(Statutory Authority: 1976 Code Sections 1–23–110, 38–3–110, and 38–13–1030)

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Section I. Authority

These regulations are promulgated pursuant to the authority granted by Section 38–13–1030 of the Insurance Law.

Section II. Purpose.

The purpose of these regulations is to set forth the 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 Section 38—13–1000 et seq.

Section III. Definitions.

A. ''Director.'' The South Carolina Director of Insurance or his designee.

B. ''Insurance group.'' For the purpose of this Act, the term ''insurance group'' shall mean those insurers and affiliates included within an insurance holding company system as defined in Section 38–13–1000 et seq.

C. ''Insurer.'' The term ''insurer'' shall have the same meaning as set forth in Regulation 69–3, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

D. ''Senior Management.'' The term ''senior management'' shall mean 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.

Section IV. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by the Corporate Governance Annual Disclosure Act, Section 38—13–1000 et seq., shall, no later than June 1 of each calendar year, submit to the director a CGAD that contains the information described in Section V of these regulations.

B. The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter ''Board'') or at the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations 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. 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 upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or 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 the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in Section 38–13–1020 of the Insurance Law, 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 most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. 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 Section V. 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 regulator.

Section V. Contents of Corporate Governance Annual Disclosure

A. 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. 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 various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) 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 Chief Executive Officer (CEO) and Chairman of the Board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, 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. 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 adjustment and how those adjustments are incorporated in to the program 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 restarted or otherwise adjusted;

(f) Any other factors relevant in 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. 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 that 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 pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(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.

Section VI. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is hold invalid, such determination shall not affect other provisions or applications of these regulations

which can be given effect without the invalid provision or application, and to that end the provision of these regulations are severable.

HISTORY: Added by SCSR 43–5 Doc. No. 4836, eff May 24, 2019. Amended by SCSR 44–6 Doc. No. 4929, eff June 26, 2020.