PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

House Business Committee

66th Idaho Legislature
Second Regular Session – 2022

Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2022

BRAD LITTLE
Governor

ALEX J. ADAMS
Administrator

State of Idaho
DIVISION OF FINANCIAL MANAGEMENT
Executive Office of the Governor

January 10, 2022

M E M O R A N D U M

TO: **Members of the 2022 Idaho State Legislature**

FROM: **Alex J. Adams, Administrator**
Bradley A. Hunt, Rules Coordinator

SUBJECT: **Overview of Executive Agency Rulemaking in 2021**

Background. Governor Little maintains and continues to stress the importance of an efficiently functioning government along with ensuring continuity of the services citizens expect and implemented through executive administrative rules. Nearly all rules published in the Legislative Rules Review books are simply re-published because the 2021 Legislature adjourned *sine die* without passing a concurrent resolution approving any pending fee rules as specified in Section 67-5224, Idaho Code, as well as not extending any effective rule on July 1 by statute as outlined in Section 67-5292, Idaho Code. The necessary rules were re-published in the following special bulletins:

- July 21 – Temporary Rules
- October 20 – Proposed Rules
- December 22 – Pending Rules

Changes in Existing Rules. Since the vast majority of rules either expired or were not approved, there is no existing rule available to amend. Therefore, only a clean version of the rule chapter is able to be presented to the Legislature in January 2022. In some cases, rules were modified based on public comment, or to implement Executive Order 2020-01, Zero-Based Regulation (ZBR), among other reasons. Given the unprecedented volume, edits are incorporated within a single omnibus docket, or in the case of ZBR rulemaking a standalone docket, and presented as a clean rule chapter. There are several ways that legislators may view previous rules for comparison purposes:

- An archive of any rule since 1996 is available on the DFM website. This allows legislators to see the evolution of a rule over time.
- The Legislative Services Office analyzes all proposed rules. You can find their analysis of proposed rules which, in some cases, may discuss changes between previous rules and the proposed rules. These may be found on the Legislature's website.
- Changes made between the proposed and pending rule stages for omnibus rulemaking were noted in the December 22 bulletin where applicable.

Process for Approving Rules. Below, you will find a brief description on legislative actions and outcomes regarding the rules review process and contents of the Legislative Rules Review Books:

- Pending Fee Rules must be affirmatively approved by both bodies via adoption of concurrent resolution to become final.
- Pending Rules become final and effective sine die unless rejected, in whole or in part, via concurrent resolution adopted by both bodies.
    - Pending rules may be approved, in whole or in part, or rejected if determined to be inconsistent with legislative intent of the governing statute.
    - If rejected, new or amended language must be identified at a numerical or alphabetical designation within the rule and specified in the concurrent resolution.
- A link to LSO's proposed rule analysis is provided at the beginning of each docket and includes any required supporting documentation (e.g. Cost Benefit Analysis (CBA), Incorporation By Reference Synopsis (IBRS)) as part of the analysis.
- All 2022 review books can be accessed on the DFM website here.

Contact Information. If questions arise during the rules review process, please do not hesitate to contact the Rules Coordinator, Brad Hunt: Brad.Hunt@dfm.idaho.gov; 208-854-3096.

HOUSE BUSINESS COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2022 Legislative Session

IDAPA 12 – IDAHO DEPARTMENT OF FINANCE

DOCKET NO. 12-0000-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or date specified in, the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 26-2144, 26-31-103, 26-31-204, and 26-31-302, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 12, rules of the Idaho Department of Finance:

IDAPA 12
- 12.01.04, *Rules Pursuant to the Idaho Credit Union Act*; and
- 12.01.10, *Rules Pursuant to the Idaho Residential Mortgage Practices Act*.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rulemaking was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, Vol. 21-10SE, pages 1065-1073.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Anthony Polidori, (208) 332-8060.

Dated this 22nd day of December, 2021.

Anthony Polidori
Deputy Director
Idaho Department of Finance
800 Park Blvd., Suite 200
P.O. Box 83720
Boise, ID 83720-0031
Phone: (208) 332-8060
Fax: (208) 332-8099

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 26-2144, 26-31-103, 26-31-204, and 26-31-302, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 12, rules of the Idaho Department of Finance:

IDAPA 12
- 12.01.04, *Rules Pursuant to the Idaho Credit Union Act*; and
- 12.01.10, *Rules Pursuant to the Idaho Residential Mortgage Practices Act*.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Anthony Polidori, (208) 332-8060.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 12-0000-2100

12.01.04 – RULES PURSUANT TO THE IDAHO CREDIT UNION ACT

000. LEGAL AUTHORITY.
This chapter is promulgated pursuant to Section 26-2144, Idaho Code. ( )

001. SCOPE.
These rules implement statutory intent with respect to the regulation and supervision of state chartered credit unions in the state of Idaho. ( )

002. -- 004. (RESERVED)

005. DEFINITIONS.
The definitions used in this chapter are as follows: ( )

01. **Act**. Means the Idaho Credit Union Law, Chapter 21, Title 26, Idaho Code. ( )

02. **Applicant**. Means a group of persons applying for a credit union charter. ( )

03. **Department**. Means the Idaho Department of Finance. ( )

04. **Director**. Means the Director of the Department. ( )

05. **Corporate Credit Union**. Means a corporate credit union chartered under the provisions of the act. ( )

06. **Credit Union**. Means a credit union chartered under the provisions of the act. ( )

07. **NCUA**. Means the National Credit Union Administration. ( )

006. -- 009. (RESERVED)

010. CHARTER APPLICATIONS.

01. **Guidelines for Approval of Credit Union Charters**. Each application for a credit union shall set forth or show: ( )

a. The proposed name of the credit union; ( )

b. The city, county, or area in which the proposed credit union is to hold its charter; ( )

c. A description of the common bond for the field of membership of the potential members of the credit union. Said field of membership should indicate that there are enough potential members to allow the proposed credit union to successfully carry on credit union operations; ( )

d. That the stability of employment of the potential members of the credit union or that the stability of membership in the association which comprises the common bond of membership is sufficient to allow the credit union to maintain a stable level of participation by members; ( )

e. The economic characteristics of the proposed field of membership indicating the ability of members to provide funds in sufficient amounts to carry out the purposes for which the credit union is formed; ( )

f. That the persons who form the common bond and potential field of membership of the credit union have indicated sufficient interest in the credit union that the Director may reasonably believe that credit union operations may be carried out successfully. ( )

011. -- 019. (RESERVED)

020. SERVICES, ADVERTISING, REPORTING CRIMES, BONDS.

01. Credit Union Services. ( )

a. A credit union shall not allow, by contract or otherwise, any credit union bookkeeping or record keeping services for itself, whether on or off premises, unless assurances satisfactory to the Director are provided by both the credit union and the party performing such services, which indicate that the performance thereof will be subject to rule and examination by the Director or his duly authorized representative to the same extent as if such services were being performed by the credit union itself on its own premises. If this service is "on premises" then prior written approval of the Director must be obtained before service is sold or otherwise made available to any outside customer. ( )

b. The assurances referred to above shall be submitted prior to the time the contract or agreement becomes effective in the form of letters from both parties and signed by a duly authorized officer of the credit union and by the party, or duly authorized officer or representative of such party, stating they will perform the services for the credit union, that the credit union and the party performing such services have entered into an agreement, that the performance of the services will be subject to rule and examination by the Director, and that such performance of services will be made available for examination. A copy of the contract or agreement covering these services shall accompany these letters. ( )

02. Advertising. ( )

a. A credit union shall not issue, circulate, or publish any advertisement which misrepresents the nature of its shares, stocks, investments, certificates, or the rights of shareholders in respect thereto. ( )

b. No credit union may in any advertisement: ( )

i. Use the words "chartered by the state of Idaho" unless said credit union has been issued a charter by the Director; ( )

ii. Use the words "National Credit Union Share Insurance Fund" or any facsimile thereof; nor use any insignia, seal, or device whatsoever which represents that the shares or deposits of the credit union are insured by the Administrator, NCUA, unless, in fact, the credit union is so insured. ( )

c. The Director upon written notification to any or all credit unions may require that a true copy of the text of any advertisement be filed with his office at least five (5) days prior to the issuance, circulation, or publication of such advertisement. ( )

021. -- 039. (RESERVED)

040. MEMBER BUSINESS LOANS.

01. Definitions. For the purposes of this rule, the following definitions apply: ( )

a. The term "member business loan" means any loan, line of credit, or letter of credit, the proceeds of which will be used for a commercial, business, or agricultural purpose, except the following are not considered member business loans for the purpose of this rule: ( )

i. A loan or loans fully secured by a lien on a one to four family dwelling that is either the member's primary residence, or the member's secondary residence. ( )

ii. A loan that is fully secured by shares in the credit union or deposits in other financial institutions. ( )

iii. A loan, the proceeds of which are used for a commercial, business, or agricultural purpose, made to a borrower or an associated member, which, when added to such other loans to the borrower, is less than fifteen thousand dollars ($15,000). ( )

iv. A loan, the repayment of which is fully insured or fully guaranteed by, or where there is an advance commitment to purchase in full by, an agency of the federal government or a state or any of its political subdivisions. ( )

b. "Reserves" means all reserves including the allowance of loan losses account and undivided earnings or surplus. ( )

c. "Associated Member" means any member with a common ownership, investment or other pecuniary interest in a business or commercial endeavor. ( )

d. "Immediate Family Member" means a spouse or other family members, related by blood or operation of law, living in the same household. ( )

02. Requirements. A credit union may make member business loans only in accordance with the following requirements: ( )

a. Written Loan Policies. Except as provided in this section, the board of directors must adopt specific business loan policies within sixty (60) days of the effective date of this rule and review them at least annually. A credit union must submit the proposed written policies, and any future amendments to the policies, to the Director for approval at least thirty (30) days prior to the proposed date of implementation of the member business loan program or amendments. Any credit union that is NCUA insured must also provide notice and a copy of the loan policies or amendments to the appropriate NCUA regional office within thirty (30) days before adoption and implementation of the policies or amendments. ( )

b. Credit Unions that do not intend to make member business loans do not have to adopt and implement these policies. However, if such a credit union decides to begin making member business loans at some time in the future, the requirements of this section will apply, except that the specific business loan policies must be adopted and implemented no less than thirty (30) days before any member business loan is made that, at a minimum, address the following: ( )

i. Types of business loans that will be made. ( )

ii. The credit union's trade area for business loans. ( )

iii. Maximum amount of the credit union's assets in relationship to reserves that will be invested in business loans, not to exceed three hundred percent (300%). ( )

iv. Maximum amount of credit union assets in relationship to reserves that will be invested in a given category or type of business loan. ( )

v. Maximum amount of credit union assets, in relation to reserves, that will be loaned to any one (1) member or group of associated members. ( )

vi. Qualifications and experience of personnel involved in making and administering business loans. ( )

vii. Analysis of ability of the borrower to repay the loan. ( )

viii. The following considerations shall be addressed unless the board of directors finds that they are not appropriate for a particular type of business loan and states the reasons for those findings in the credit union's written policies: balance sheet, trend and structure analysis; ratio analysis of cash flow, income and expenses, and tax data; leveraging; comparison with industry averages; receipt and periodic updating of financial statements and other documentation, including tax returns. ( )

ix. Collateral requirements, including loan-to-value ratios; appraisals, title search and insurance requirements; steps to be taken to secure various types of collateral; and how often the value and marketability of collateral is to be reevaluated. ( )

x. Appropriate interest rates and maturities of business loans. ( )

xi. Loan monitoring, servicing, and follow-up procedures, including collection procedures. ( )

c. Loans to One (1) Member. The following restrictions apply to credit unions loans to one (1) member. ( )

i. The aggregate amount of outstanding member business loans to any one (1) member or group of associated members shall not exceed twenty percent (20%) of the credit union's reserves. ( )

ii. If any portion of a member business loan is fully secured by a one (1) to four (4) family dwelling that is the member's primary residence or secondary residence, or by shares in the credit union or deposits in another financial institution, or insured or guaranteed by, or subject to an advance commitment to purchase by, any agency of the federal government or of a state or any of its political subdivisions, such portion shall not be calculated in determining the twenty percent (20%) limit. ( )

iii. Credit unions seeking an exception from the twenty percent (20%) limit must present to the Director the higher limit sought, an explanation of the need to raise the limit, an analysis of the credit union's prior experience making member business loans, and a copy of its business lending policy. In addition, at the same time this information is presented to the Director, any credit union that is NCUA insured must also submit a copy of the information to the appropriate NCUA regional office for its review and comment. ( )

iv. Any decision by the Director to grant any request to exceed the twenty percent (20%) loan-to-one borrower's limit will be made only after consultation and coordination with NCUA. ( )

d. Allowance for Loan Losses. The determination of whether a member business loan will be classified as substandard, doubtful, or loss will rely on factors not limited to the delinquency of the loan. Non-delinquent loans may be classified, depending on an evaluation of factors including, but not limited to, the adequacy of analysis and documentation. ( )

e. Loans classified shall be reserved as follows: ( )

i. Loss loans at one hundred percent (100%) of outstanding amount; ( )

ii. Doubtful loans at fifty percent (50%) of outstanding amount; and ( )

iii. Substandard loans at ten percent (10%) of outstanding amount, unless other factors (e.g., history of such loans at the credit union) indicate that a greater or lesser amount is appropriate. ( )

03. Prohibitions. A credit union may not make member business loans to the following nonvolunteer, senior management employees, or to any associated member or immediate family member of such employees: ( )

a. The credit union's chief executive officer; typically this individual holds the title of president, treasurer, or manager. ( )

b. Any assistant chief executive officers; often the assistant manager. ( )

c. The chief financial officer or comptroller. The credit union shall not grant a member business loan where any provision for the payment, or the amount of the payment, on the loan is conditioned on the profitability or success of the business or commercial endeavor for which the loan is made. ( )

041. -- 049. (RESERVED)

050. NONPREFERENTIAL TREATMENT.

01. Nonpreferential Treatment. The rates, terms, and conditions on any loan or line of credit either made to, or endorsed or guaranteed by: ( )

a. An official; ( )

b. An immediate family member of an official; or ( )

c. Any individual having a common ownership, investment, or other pecuniary interest in a business enterprise with an official or with an immediate family member of an official, cannot be more favorable than the rates, terms, and conditions for comparable loans or lines of credit to other credit union members. "Official" means any member of the board of directors, credit committee, or supervisory committee. "Immediate family member" means a spouse or other family members, related by blood or operation of law, living in the same household. ( )

051. -- 059. (RESERVED)

060. PROHIBITED FEES, COMMISSIONS, COMPENSATION.
A credit union may not make any loan or extend any line of credit if, either directly or indirectly, any commission, fee, or other compensation is to be received by the credit union's directors, committee members, senior management employees, loan officers, or any immediate family members of such individuals, in connection with underwriting, insuring, servicing, or collecting the loan or line of credit. However, salary for employees is not prohibited by this section. "Senior management employees" refers to those employees described in Subsection 040.03 of these rules. "Immediate family member" means a spouse, or other family members, related by blood or operation of law, living in the same household. ( )( )

061. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
This chapter is promulgated pursuant to Sections 26-31-103, 26-31-204(5), 26-31-302(1)(a), and 26-31-302(2), Idaho Code. ( )

001. SCOPE.
These rules interpret the Idaho Residential Mortgage Practices Act, Title 26, Chapter 31, Idaho Code. ( )

002. -- 004. (RESERVED)

005. INCORPORATION BY REFERENCE.
For the purposes of the Act and these rules the full text of the following are incorporated by reference: ( )

01. The Real Estate Settlement Procedures Act. As set forth in 12 U.S.C. 2601, et seq., as amended to and including January 1, 2020. The Real Estate Settlement Procedures Act is available for viewing online at: https://www.gpo.gov/fdsys/pkg/USCODE-2016-title12/html/USCODE-2016-title12-chap27.htm. ( )

02. Regulation X. As issued by the federal Bureau of Consumer Financial Protection and codified at 12 CFR 1024, et seq., as amended to and including January 1, 2020. Regulation X is available for viewing online at: https://www.gpo.gov/fdsys/pkg/CFR-2018-title12-vol8/xml/CFR-2018-title12-vol8-part1024.xml. ( )

03. The Truth in Lending Act. As set forth in 15 U.S.C. 1601, et seq., as amended to and including January 1, 2020. The Truth in Lending Act is available for viewing online at: https://www.gpo.gov/fdsys/pkg/USCODE-2016-title15/html/USCODE-2016-title15-chap41.htm. ( )

04. Regulation Z. As issued by the federal Bureau of Consumer Financial Protection and codified at 12 CFR 1026, et seq., as amended to and including January 1, 2020. Regulation Z is available for viewing online at: https://www.gpo.gov/fdsys/pkg/CFR-2018-title12-vol9/xml/CFR-2018-title12-vol9-part1026.xml. ( )

05. Availability of Documents. Unless otherwise available, the documents incorporated by reference may be viewed at the central office of the Idaho Department of Finance. ( )

006. DEFINITIONS.
In addition to the terms defined in the Idaho Residential Mortgage Practices Act, the following definitions apply: ( )

01. Act. The Idaho Residential Mortgage Practices Act, Title 26, Chapter 31, Idaho Code. ( )

02. Application. In relation to a "residential mortgage loan" or "loan modification" as defined in the Act, an "application" means a request for a residential mortgage loan or loan modification and any form or document representing such request. The term "application" does not include the processing of such request. ( )

03. Closing. The process of executing legally binding documents regarding a lien on property that is subject to a residential mortgage loan and includes the day agreed upon by a borrower and a covered person to complete such process. ( )

04. Covered Person. A person who has been issued a license, pursuant to the Act, or a person required to be licensed under the Act. ( )

007. -- 039. (RESERVED)

040. DECEPTIVE ADVERTISING.

01. Advertising. Advertising means making or permitting to be made any oral, written, graphic or pictorial statements, in any manner, in the course of the solicitation of business authorized under the Act. Deceptive advertising is defined to include the following practices by a covered person: ( )

a. Advertising without clearly and conspicuously disclosing the business name and unique identifier assigned by the Nationwide Mortgage Licensing System and Registry (NMLSR) to the covered person. ( )

b. Engaging in bait and switch advertising or misrepresenting, directly or indirectly, the terms, conditions or charges incident to services authorized under the Act. Bait and switch advertising, for the purposes of

these rules, means advertising services without the intent to provide them but, rather, to lure a person into making an application for services and then switch the person from obtaining the advertised services to other or different services on a basis more advantageous to the covered person. ( )

c. Using an address in advertising at which the covered person conducts no mortgage brokering, mortgage lending, or mortgage loan origination activities or for which the covered person does not hold a license. ( )

d. Advertising or soliciting in a manner that has the effect of misleading a person to believe that the advertisement or solicitation is from a person's current mortgage holder, a government agency, or that an offer is a limited opportunity, when such is not the case. ( )

041. -- 049. (RESERVED)

050. WRITTEN DISCLOSURES.

01. Receipt of an Application. Upon receipt of an application as defined in Subsection 006.02 of these rules, and before receipt of any moneys from a borrower, a covered person shall make available to each borrower information, in a manner acceptable to the Director, about the services authorized under the Act that he may provide to a borrower. ( )

02. Loan Modification Confirmation. Within three (3) business days, including Saturdays, of receipt of a notice from a creditor or its agent of a loan modification offer, a covered person shall deliver or send by first-class mail to the borrower a written confirmation of the terms of the loan modification offer. Such confirmation shall include information regarding proposed rates, payments, and loan balance. ( )

051. RESTRICTIONS ON FEES.
If a covered person imposes fees authorized by Section 26-31-210 of the Act, the following restrictions apply, subject to the Director's authority to set limits on fees and charges pursuant to Section 26-31-204(6) of the Act: ( )

01. Application Fee. An application fee shall include only the actual costs incurred by a covered person in connection with the taking of an application and transcribing application information. ( )

02. Cancellation Fee. A cancellation fee may only be charged at the time of, or subsequent to, a request or instruction by a borrower to a covered person to cancel a request for services authorized under the Act. Such fee must bear a reasonable relationship to the actual costs incurred by the covered person for services provided to a borrower up to the borrower's request or instruction to cancel the request for services. A cancellation fee must comply with the requirements of Regulation Z, when applicable. ( )

052. -- 059. (RESERVED)

060. PROHIBITED PRACTICES.
It is a prohibited practice for any covered person in connection with offering or providing services authorized under the Act, to: ( )

01. Fail to Disburse Funds Timely. Fail to disburse funds in a timely manner, in accordance with any commitment or agreement with the borrower, either directly or through a mortgage broker: ( )

a. Either immediately upon closing of the loan in the case of a purchase/sale transaction; or ( )

b. Immediately upon expiration of the three (3) day rescission period in the case of a refinancing, or taking of a junior mortgage on the existing residence of the borrower. ( )

c. For the purposes of this Subsection, the term "immediately" represents a period of time no greater than seventy-two (72) hours. ( )

02. Fail to Provide Reasonable Opportunity for Document Review. Fail to give the borrower, upon

the borrower's verbal or written request, a reasonable opportunity of at least twenty-four (24) hours prior to closing to review every document to be signed or acknowledged by the borrower for the purpose of obtaining a residential mortgage loan, and every document that is required pursuant to these rules, and other applicable laws, rules or regulations. ( )

03. Require Excessive Insurance. Require a borrower to obtain or maintain fire insurance or other hazard insurance in an amount that exceeds the replacement value of the improvements to the real estate. ( )

04. Engage in Deceptive Advertising. Engage in any deceptive advertising as set forth in Section 040 of these rules. ( )

061. -- 089. (RESERVED)

090. BORROWERS UNABLE TO OBTAIN LOANS.
If, for any reason, a covered person fails to obtain a residential mortgage loan for a borrower that is satisfactory to the borrower, and the borrower has paid for an appraisal, the covered person shall provide a copy of the appraisal to the borrower and transmit and assign original appraisal reports, along with any other documents provided by the borrower, to any other person to whom the borrower directs that the documents be transmitted. The covered person shall provide such copies or transmit such documents within three (3) business days after the borrower makes the request in writing. ( )

091. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

DOCKET NO. 18-0000-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or date specified in, the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211 and 41-254, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 18, rules of the Department of Insurance:

All Lines:
- 18.01.01, *Rule to Implement the Privacy of Consumer Financial Information*.

Property, Casualty, Automobile Insurance:
- 18.02.02, *Automobile Insurance Policies*; and
- 18.02.03, *Certificate of Liability Insurance for Motor Vehicles*.

Life & Annuity:
- 18.03.02, *Life Settlements*;
- 18.03.03, *Variable Contracts*; and
- 18.03.04, *Replacement of Life Insurance and Annuities*.

Health & Disability Insurance:
- 18.04.03, *Advertisement of Disability (Accident and Sickness) Insurance*;
- 18.04.04, *The Managed Care Reform Act Rule*;
- 18.04.05, *Self-Funded Health Care Plans Rule*;
- 18.04.06, *Governmental Self-Funded Employee Health Care Plans Rule*;
- 18.04.08, *Individual and Group Supplementary Disability Insurance Minimum Standards Rule*;
- 18.04.11, *Long-Term Care Insurance Minimum Standards*;
- 18.04.12, *The Small Employer Health Insurance and Availability Act*;
- 18.04.13, *The Individual Health Insurance Availability Act*;
- 18.04.14, *Coordination of Benefits*; and
- 18.04.15, *Rules Governing Short-Term Health Insurance Coverage*.

Title Insurance:
- 18.05.01, *Rules for Title Insurance Regulation*.

Agents & Licensing:
- 18.06.01, *Rules Pertaining to Bail Agents*;
- 18.06.02, *Producers Handling of Fiduciary Funds*;
- 18.06.03, *Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees*;
- 18.06.05, *Managing General Agents*; and
- 18.06.06, *Surplus Line Rules*.

Company Operations & Solvency:

- 18.07.01, *Rules Pertaining to Acquisitions of Control, Insurance Holding Company Systems and Mutual Insurance Holding Companies*;
- 18.07.02, *Reserve Liabilities and Minimum Valuations for Annuities and Pure Endowment Contracts*;
- 18.07.03, *Valuation of Life Insurance Policies Including the Use of Select Mortality Factors*;
- 18.07.04, *Annual Financial Reporting*;
- 18.07.05, *Director's Authority for Companies Deemed to be in Hazardous Financial Condition*;
- 18.07.06, *Rules Governing Life and Health Reinsurance Agreements*;
- 18.07.08, *Property and Casualty Actuarial Opinion Rule*;
- 18.07.09, *Life and Health Acutarial Opinion and Memorandum Rule*; and
- 18.07.10, *Corporate Governance Annual Disclosure*.

State Fire Marshal:

- 18.08.01, *Adoption of the International Fire Code*.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rulemaking was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, Vol. 21-10SE, pages 2781-3010.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Dated this 22nd day of December, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720, Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211 and 41-254, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 18, rules of the Department of Insurance:

IDAPA 18

All Lines:
- 18.01.01, *Rule to Implement the Privacy of Consumer Financial Information*.

Property, Casualty, Automobile Insurance:
- 18.02.02, *Automobile Insurance Policies*; and
- 18.02.03, *Certificate of Liability Insurance for Motor Vehicles*.

Life & Annuity:
- 18.03.02, *Life Settlements*;
- 18.03.03, *Variable Contracts*; and
- 18.03.04, *Replacement of Life Insurance and Annuities*.

Health & Disability Insurance:
- 18.04.03, *Advertisement of Disability (Accident and Sickness) Insurance*;
- 18.04.04, *The Managed Care Reform Act Rule*;
- 18.04.05, *Self-Funded Health Care Plans Rule*;
- 18.04.06, *Governmental Self-Funded Employee Health Care Plans Rule*;
- 18.04.08, *Individual and Group Supplementary Disability Insurance Minimum Standards Rule*;
- 18.04.11, *Long-Term Care Insurance Minimum Standards*;
- 18.04.12, *The Small Employer Health Insurance and Availability Act*;
- 18.04.13, *The Individual Health Insurance Availability Act*;
- 18.04.14, *Coordination of Benefits*; and
- 18.04.15, *Rules Governing Short-Term Health Insurance Coverage*.

Title Insurance:
- 18.05.01, *Rules for Title Insurance Regulation*.

Agents & Licensing:
- 18.06.01, *Rules Pertaining to Bail Agents*;
- 18.06.02, *Producers Handling of Fiduciary Funds*;
- 18.06.03, *Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees*;
- 18.06.05, *Managing General Agents*; and
- 18.06.06, *Surplus Line Rules*.

Company Operations & Solvency:
- 18.07.01, *Rules Pertaining to Acquisitions of Control, Insurance Holding Company Systems and Mutual Insurance Holding Companies*;
- 18.07.02, *Reserve Liabilities and Minimum Valuations for Annuities and Pure Endowment Contracts*;
- 18.07.03, *Valuation of Life Insurance Policies Including the Use of Select Mortality Factors*;
- 18.07.04, *Annual Financial Reporting*;
- 18.07.05, *Director's Authority for Companies Deemed to be in Hazardous Financial Condition*;
- 18.07.06, *Rules Governing Life and Health Reinsurance Agreements*;
- 18.07.08, *Property and Casualty Actuarial Opinion Rule*;
- 18.07.09, *Life and Health Acutarial Opinion and Memorandum Rule*; and
- 18.07.10, *Corporate Governance Annual Disclosure*.

State Fire Marshal:
- 18.08.01, *Adoption of the International Fire Code*.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rule(s) being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 18-0000-2100

18.01.01 – RULE TO IMPLEMENT THE PRIVACY OF CONSUMER FINANCIAL INFORMATION

000. LEGAL AUTHORITY.
Title 41, Chapter 13, Section 41-1334, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.01.01, "Rule to Implement the Privacy of Consumer Financial Information." ( )

02. Scope. This rule describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties and provides methods for individuals to prevent a licensee from disclosing that information. ( )

03. Applicability. This rule applies to nonpublic personal financial information about individuals who obtain or are beneficiaries of products or services primarily for personal, family, or household purposes from licensees. This rule does not apply to information about companies or individuals who obtain products or services for business, commercial, or agricultural purposes. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
All terms defined in Title 41, Chapters 1 and 13, Idaho Code, that are used in this rule have the same meaning as used in those chapters. In addition, the following terms are defined as used in this chapter. ( )

01. Clear and Conspicuous. ( )

a. A notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice if it: ( )

i. Presents the information 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; ( )

vi. Avoids explanations that are imprecise and readily subject to different interpretations. ( )

vii. Uses an easy-to-read typeface and type size, and uses boldface or italics for key words; and ( )

viii. When in a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices. ( )

b. If a licensee provides a notice on a web page, the notice needs to call attention to the nature and significance of the information in the notice and place the notice on a screen that consumers frequently access, or place a link on a screen that consumers frequently access that connects directly to the notice. ( )

02. Collect. To obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifiers assigned to the individual. ( )

03. Company. A corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization. ( )

04. Consumer. An individual who seeks to obtain, obtains, or has obtained an insurance product or

service from a licensee used primarily for personal, family, or household purposes. Examples: ( )

a. An individual who provides nonpublic personal information to a licensee in connection with an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship. ( )

b. 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 the financial institution. ( )

c. If the licensee provides the initial, annual, and revised notices under Sections 100, 150, and 300 of this rule to the plan sponsor, group or blanket insurance policyholder, or group annuity contract holder, and if the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about an individual other than as permitted under Sections 450, 451, and 452 of this rule, an individual is not the consumer of the licensee solely because he is: ( )

i. A participant or a beneficiary of an employee benefit plan the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary; or ( )

ii. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee. ( )

iii. A beneficiary in a workers' compensation plan. ( )

d. An individual is not a licensee's consumer solely because he is: ( )

i. A beneficiary of a trust for which the licensee is a trustee; or ( )

ii. Designated the licensee as trustee for a trust. ( )

05. Consumer Reporting Agency. Is the same meaning as found in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)). ( )

06. Control: ( )

a. 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 (1) or more other persons; ( )

b. 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 ( )

c. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines. ( )

07. Customer. A consumer who has a customer relationship with a licensee. ( )

08. Customer Relationship. A continuing relationship between a consumer and a licensee under which the licensee provides one (1) or more insurance products or services to the consumer to be used primarily for personal, family, or household purposes. ( )

a. A consumer does not have a continuing relationship with a licensee if: ( )

i. The licensee sells the consumer travel insurance in an isolated transaction; ( )

ii. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee; ( )

iii. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing either a lump sum settlement option or a settlement option involving an ongoing relationship with the licensee; ( )

iv. 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 ( )

09. Financial Institution. Any institution engaging in activities that are financial in nature. Financial institution does not include: ( )

a. 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.); ( )

b. 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 ( )

c. 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. ( )

10. Financial Product or Service. A product or service that a financial holding company could offer including 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. ( )

11. Licensee. ( )

a. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in this rule if the licensee is an employee, agent, or other representative of another licensee ("the principal") and: ( )

i. The principal complies with, and provides the notices prescribed by this rule; and ( )

ii. 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 rule. ( )

b. **A** licensee also includes an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Title 41, Chapter 12, Idaho Code. ( )

12. Nonpublic Personal Information. ( )

a. Means personally identifiable financial information; including any list, description or other grouping of consumers (see archived 18.01.48) derived using any personally identifiable financial information not publicly available. ( )

b. Nonpublic personal financial information does not include: ( )

i. Health information; ( )

ii. Publicly available information, except as included on a list described in Subparagraph 010.11.a., of this rule; or ( )

iii. Any list, description or other grouping of consumers derived without using any personally identifiable financial information that is not publicly available. ( )

13. Opt Out. A direction by the consumer that the licensee not disclose nonpublic personal financial

information about the consumer to a nonaffiliated third party. ( )

14. Personally Identifiable Financial Information. ( )

a. Any information: ( )

i. A consumer provides to a licensee to obtain an insurance product or service from the licensee; ( )

ii. About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer. ( )

b. Examples of personally identifiable financial information: ( )

i. Account balance information and payment history; ( )

ii. The fact that an individual is or has been one (1) of the licensee's customers or has obtained an insurance product or service from the licensee; ( )

iii. Information about the licensee's consumer if it is disclosed in a manner that indicates the individual is or has been the licensee's consumer; ( )

iv. Information provided by a consumer to a licensee or that the licensee or its agent obtains in connection with collecting on a loan or servicing a loan; ( )

v. Information the licensee collects through an Internet cookie (an information-collecting device from a web server); and ( )

vi. Information from a consumer report. ( )

c. Personally identifiable financial information does not include: ( )

i. Health information; ( )

ii. A list of names and addresses of customers of an entity of a non-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. ( )

15. Publicly Available Information. ( )

a. Any information that a licensee has a reasonable basis to believe is lawfully made available to the general public. ( )

011. -- 099. (RESERVED)

100. INITIAL PRIVACY NOTICE TO CONSUMERS.

01. Initial Notice Requirement. A licensee will provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to: ( )

a. A customer no later than when the licensee establishes a customer relationship, except as provided in Subsection 100.03 of this rule; and ( )

b. 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 451

and 452. ( )

02. Existing Customers. When an existing customer obtains a new insurance product or service from a licensee, which is used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of Subsection 100.01 of this rule if the 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 100.01 of this rule. ( )

03. Exceptions Allowing Subsequent Delivery of Notice. A licensee may provide the initial notice prescribed in Paragraph 100.01.a. of this rule in 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. It would avoid substantially delaying the customer's transaction and the customer agrees to receive the notice at a later time. ( )

101. -- 149. (RESERVED)

150. ANNUAL PRIVACY NOTICE TO CUSTOMERS.

01. General Rule. A licensee will 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. ( )

02. Exceptions: Termination of Customer Relationship and Duplicate Notices. ( )

a. A licensee is not obligated to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a customer relationship. ( )

i. 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. ( )

c. Notwithstanding Subsection 150.01, a licensee is not obligated to provide the annual privacy notice to a current customer if the licensee: ( )

i. Provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 450, 451, and 452; and ( )

ii. 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 Section 100 or Section 150. ( )

151. -- 199. (RESERVED)

200. INFORMATION TO BE INCLUDED IN PRIVACY NOTICES.
The initial, annual and revised privacy notices a licensee provides, under Sections 100, 150, and 300, needs to include each of the following items of information, in addition to any other information the licensee wishes to provide: ( )

01. Information Licensee Collects or Discloses. The categories of nonpublic personal financial information the licensee collects or discloses. ( )

02. Parties to Whom Licensee Discloses. The categories of third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses

information under Sections 451 and 452. ( )

03. Disclosures of Information About Former Customers. The categories of nonpublic personal financial information about the licensee's former customers the licensee discloses, and the categories of 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 451 and 452. ( )

04. Disclosures Under Section 450. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 450 (and no other exception in Sections 451 and 452 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 is to provided. ( )

05. Explanation of Right to Opt Out. An explanation of the consumer's right under Subsection 400.01 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise their right at that time. ( )

06. Disclosures Under Federal Law. Any disclosures 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)) (notices regarding the ability to opt out of disclosures of information among affiliates); and the licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information. ( )

201. DESCRIPTION OF PARTIES SUBJECT TO EXCEPTIONS.

If a licensee discloses nonpublic personal financial information as authorized under Sections 451 and 452, the licensee is not obligated to list those exceptions in the initial or annual privacy notices prescribed by Sections 100 and 150. When describing the categories of parties to whom disclosure is made, the licensee will state only that it makes disclosures to other third parties. ( )

202. SATISFYING THE PRIVACY NOTICE INFORMATION REQUIREMENTS.

01. 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, its affiliates, or third parties; ( )

c. Information from a consumer reporting agency. ( )

02. 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 it according to the source, as described in Subsection 202.01 of this rule, and provides a few examples to illustrate the types of information in each category. ( )

b. 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 the licensee discloses. ( )

03. Categories of Affiliates and Nonaffiliated Third Parties to Whom the Licensee Discloses. A licensee satisfies the requirement to categorize the 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. Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. ( )

04. Disclosures Under Exception for Service Providers and Joint Marketers. If a licensee discloses

nonpublic personal financial information under the exception in Section 450 to a nonaffiliated third party to market products or services it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection 200.04 of this rule 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 200.01 of this rule; 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. ( )

05. 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 third parties except as authorized under Sections 451 and 452, the licensee may simply state that fact, in addition to the information it provides under Subsections 200.01, 200.07, and Section 201 of this rule. ( )

06. 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. ( )

203. SHORT-FORM INITIAL NOTICE WITH OPT OUT NOTICE FOR NON-CUSTOMERS.

01. Short-Form Initial Notice Allowed. A licensee may satisfy the initial notice requirements for a consumer who is not a customer, by providing a short-form initial notice at the same time the licensee delivers an opt out notice as prescribed in Section 250. ( )

02. Short-Form Initial Notice Requirements. A short-form initial notice will: ( )

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 the notice. ( )

03. Delivery of Short-Form Initial Notice. The licensee is not obligated to deliver its privacy notice with its short-form initial notice but 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 will deliver its privacy notice according to Section 350. ( )

04. 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 the consumer may call to request the notice; ( )

b. Maintains copies of the notice on hand at the licensee’s office and provides it to the consumer immediately upon request; or ( )

c. Posts it on their website. ( )

204. -- 249. (RESERVED)

250. FORM OF OPT OUT NOTICE TO CONSUMERS.

01. Opt Out Notice Form. If a licensee is prescribed to provide an opt out notice under Subsection 400.01, it will provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under Section 400. The notice will state: ( )

a. The licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party; ( )

b. 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. ( )

02. 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: ( )

a. 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, and states that the consumer can opt out of the disclosure of that information; and ( )

b. Identifies the insurance products or services that the consumer obtains from the licensee to which the opt out direction would apply. ( )

03. Reasonable Means to Exercise an Opt Out Right. A licensee provides a reasonable means to exercise an opt out right if it: ( )

a. Designates check-off boxes in a prominent position on the relevant forms with the opt out notice; ( )

b. Includes a reply form together with the opt out notice; ( )

c. Provides an electronic means to opt out, if the consumer agrees to the electronic delivery of information; or ( )

d. Provides a toll-free telephone number that consumers may call to opt out. ( )

251. PROVIDING OPT OUT NOTICE TO CONSUMERS AND COMPLYING WITH OPT OUT DIRECTION.

01. Joint Relationships. 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 providing any of the joint consumers to 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. ( )

c. A licensee cannot require all joint consumers to opt out before it implements any opt out direction. ( )

02. Time to Comply with Opt Out. A licensee will comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it. ( )

03. Continuing Right to Opt Out. A consumer may exercise the right to opt out at any time.

( )

04. Duration of Consumer's Opt Out Direction. ( )

a. A consumer's direction to opt out under Sections 250 and 251 is effective until the consumer revokes it in writing or, if the consumer agrees, electronically. ( )

b. 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. ( )

05. Delivery. When a licensee is prescribed to deliver an opt out notice by Section 250, the licensee will deliver it according to Section 350. ( )

252. -- 299. (RESERVED)

300. REVISED PRIVACY NOTICES.

01. General Rule. A licensee will not disclose any nonpublic personal financial information other than as described in the initial notice that the licensee provided to that consumer under Section 100, unless: ( )

a. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices; ( )

b. The licensee has provided to the consumer a new opt out notice; ( )

c. 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 ( )

d. The consumer does not opt out. ( )

301. -- 349. (RESERVED)

350. DELIVERY.

01. How to Provide Notices. A licensee will make available any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically. ( )

02. Reasonable Expectation of 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; or ( )

c. For a consumer who conducts transactions electronically, or an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, 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. ( )

03. Annual Notices Only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if: ( )

a. 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 ( )

b. 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. ( )

04. Oral Description of Notice Insufficient. A licensee cannot provide any notice prescribed by this rule solely by orally explaining the notice. ( )

05. Retention or Accessibility of Notices for Customers. ( )

a. For customers only, a licensee will provide all notices so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. ( )

b. 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: ( )

i. Hand-delivers a printed copy of the notice to the customer; ( )

ii. Mails a printed copy of the notice to the last known address of the customer; or ( )

iii. 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. ( )

06. Joint Notice with Other Financial Institutions. A licensee may provide a joint notice from the licensee and one (1) 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. ( )

351. -- 399. (RESERVED)

400. LIMITS ON DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION TO NONAFFILIATED THIRD PARTIES.

01. Conditions for Disclosure. ( )

a. Except as authorized in this rule, a licensee will not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless: ( )

i. The licensee has provided to the consumer an initial notice as prescribed under Section 100; ( )

ii. The licensee has provided to the consumer an opt out notice as prescribed in Sections 250 and 251; ( )

iii. The licensee has given the consumer a reasonable opportunity to opt out of the disclosure before it discloses the information to the nonaffiliated third party; and ( )

iv. The consumer does not opt out. ( )

b. If a consumer opts out, the licensee cannot disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 450, 451, and 452. ( )

c. Examples of a reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if the licensee mails the notices prescribed in Subsection 400.01 of this rule 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 in thirty (30) days from the date of mailing. ( )

02. Application of Opt Out to All Consumers and All Nonpublic Personal Financial Information. ( )

a. A licensee will comply with Section 400, regardless of whether the licensee and the consumer have established a customer relationship. ( )

b. Unless a licensee complies with Section 400, the licensee will not 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. ( )

03. 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. ( )

401. LIMITS ON REDISCLOSURE AND REUSE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.

01. Information the Licensee Receives Under an Exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution, the licensee may disclose the information only: ( )

a. To the affiliates of the financial institution from which the licensee received the information; and ( )

b. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information. ( )

02. Information a Licensee Discloses Under an Exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party, the third party may disclose that information only: ( )

a. To the licensee's affiliates; ( )

b. 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 ( )

c. To any other person, if the disclosure would be lawful if the licensee made it directly to that person. ( )

402. LIMITS ON SHARING ACCOUNT NUMBER INFORMATION FOR MARKETING PURPOSES. A licensee will 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. ( )

403. -- 449. (RESERVED)

450. EXCEPTION TO OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR SERVICE PROVIDERS AND JOINT MARKETING.

01. General Rule. ( )

a. The opt out requirements in Sections 250, 251 and 400 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: ( )

i. Provides the initial notice in accordance with Section 100; and ( )

ii. 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 Section 451 or 452 in the ordinary course of business to carry out those purposes. ( )

451. EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR PROCESSING AND SERVICING TRANSACTIONS.

01. Exceptions. The requirements for initial notice in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 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: ( )

a. Servicing or processing an insurance product or service that a consumer requests or authorizes; ( )

b. 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; ( )

c. A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or ( )

d. Reinsurance or stop loss or excess loss insurance. ( )

452. OTHER EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.

01. Exceptions to Opt Out Requirements. The requirements for initial notice to consumers in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 do not apply when a licensee discloses nonpublic personal financial information: ( )

a. With the consent or at the direction of the consumer; ( )

b. To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction; ( )

c. To protect against or prevent actual or potential fraud or unauthorized transactions; ( )

d. For prescribed institutional risk control or for resolving consumer disputes or inquiries; ( )

e. To persons holding a legal or beneficial interest relating to the consumer; or ( )

f. To persons acting in a fiduciary or representative capacity on behalf of the consumer; ( )

g. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies rating a licensee, persons assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors; ( )

h. To the extent specifically permitted or prescribed 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, and the Federal Trade Commission), 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 Recordkeeping), a state insurance authority, self-regulatory organizations or for an investigation on a matter related to public safety; ( )

i. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or from a consumer report reported by a consumer reporting agency; ( )

j. 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; ( )

k. To comply with federal, state or local laws, rules, and other applicable legal requirements; to comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; ( )

l. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan; or ( )

m. With the consent of or at the direction of a liquidator or rehabilitator appointed pursuant to Chapter 33, Title 41, Idaho Code. ( )

453. -- 499. (RESERVED)

500. NONDISCRIMINATION.
A licensee will not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of their nonpublic personal financial information pursuant to the provisions of this rule. ( )

501. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 25, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.02.02, "Automobile Insurance Policies." ( )

02. Purpose. Provides guidelines to assist in the implementation and uniform interpretation of the following Sections 41-2502, 41-2506, 41-2507, 41-2508, and 41-2509 of the Idaho Code. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
The Idaho Department of Insurance adopts the definitions set forth in Title 41, Chapter 25, Idaho Code. In addition, the following terms are defined as used in this chapter. ( )

01. The Act. For the purpose of this Rule, the term "the Act," unless otherwise noted, refers to Sections 41-2506, 41-2507, 41-2508, 41-2509, 41-2510, 41-2511, 41-2512, Idaho Code. ( )

02. Non-Payment of Premium. The time and date of cancellation of a policy for non-payment of premium will be no earlier than ten (10) days after the date such notice was mailed or delivered, the date of mailing is the first day and the tenth day ends at midnight, standard time, at the last known address of the named insured. Nothing in this rule is construed to permit any agent or other representative of the insurer to cancel any policy without the agreement of the insurer or for any private debt between the agent and the insured. Also, nothing in the section is construed to prohibit a policy from being canceled effective as of any date mutually acceptable to the insured, the insurer and the lienholder, if any. Furthermore, a prior existing policy will terminate on the effective date of any other policy procured by the insured with respect to any automobile designated in both policies and containing duplicate insurance coverage. ( )

03. Sixty-Day Period. Should an insurer, after the sixty-day (60) period referred to in Section 41-2506, Idaho Code, find that after investigation of a particular risk, conclude that it does not wish to remain on the risk, it may decline to continue such policy in force. Therefore, an insurer may deliver notice of cancellation or mail notice of cancellation concerning any new automobile policy on or before the sixtieth (60th) day after the effective date of the policy. The policy will remain in force from the date the notice of cancellation is mailed to the usual date the cancellation is effective as prescribed by the terms and conditions of the policy, without the policy being subject to the provisions of the Act. ( )

011. ERRORS OR MISREPRESENTATIONS IN THE APPLICATION.

01. Material Misrepresentation. An insurer may cancel or refuse to renew a policy after giving the insured proper notice if the insurer has evidence the named insured, or legal representative, made fraudulent or material misrepresentations, omissions, concealment of facts or incorrect statements in obtaining the policy and if the insurer in good faith would not have issued the policy or provided coverage with respect to a particular hazard if the true facts had been made known to the insurer as prescribed in the application. ( )

02. Prohibitions. Nothing in this rule is construed to allow the insurer to void the policy back to its effective date or rescind coverage under the policy to prevent a recovery under the policy in the event of a loss otherwise insured by the policy. ( )

012. ALLOWABLE CONVICTIONS FOR TRAFFIC VIOLATIONS.

01. Grounds and Requests for Cancellation Due to Traffic Violation Convictions. For purposes of Section 41-2507, Idaho Code, **t**he term "conviction" means a final conviction by any court having competent jurisdiction over violations of laws regulating the operation of motor vehicles. ( )

02. Conviction Exception. For the purposes of the Act, an overtime parking violation is not considered a conviction. ( )

013. NOTICE OF PREMIUM DUE AS WILLINGNESS OF INSURER TO RENEW.
Mailing by the insurer of the renewal premium notice constitutes willingness by the insurer to renew. If the insured fails to pay the renewal premium when due, the policy will terminate in accordance with its terms. No further notice

to the insured by the insurer of an intention not to renew for non-payment of premium is necessary. ( )

014. ACCEPTABLE FORMS FOR NOTICE OF CANCELLATION, REFUSAL TO RENEW, AND AVAILABILITY OF IDAHO AUTOMOBILE INSURANCE PLAN.

01. Notice Forms. The insurer will prepare forms of notice to use and submit to the Director for approval. ( )

02. Acceptable Language. As a guide, the Department may accept the following language, or language substantially similar, as satisfying the indicated notice requirements of the Act: ( )

a. Right of Insured to Request Reasons for Cancellation by Insurer: Upon your written request, mailed or delivered to (Name of Insurer) not less than ten (10) days prior to the effective date of this cancellation, (Name of Insurer) will supply to you the reason or reasons why your policy has been canceled." ( )

b. Right of Insured to Request Reasons for Refusal to Renew by Insurer: Upon your written request, mailed or delivered to (Name of Insurer) not less than fifteen (15) days prior to the expiration date of your policy, which is the date coverage ceases under your policy unless it is renewed, the (Name of Insurer) will supply to you the reason or reasons why your policy will not be renewed." ( )

c. Notification to Insured of Coverage Available Under Idaho Automobile Insurance Plan: "Should you experience difficulty in obtaining automobile liability insurance, please contact your agent or company representative for full particulars concerning your possible eligibility for insurance through the Idaho Automobile Insurance Plan." ( )

015. STANDARD STATEMENT REGARDING UNINSURED AND UNDERINSURED MOTORIST COVERAGE.

The form set forth on the Department's website is the standard statement approved by the Director pursuant to Section 41-2502, Idaho Code, and carriers are to use the form for all new policies and those existing policies where UM or UIM coverage is added or removed. Carriers may make non-substantive changes to this form, for example, including inserting company letterhead, and carriers need to file their standard statement forms with the Director prior to use. This rule does not create new requirements for the types of UIM coverage carriers offer beyond what existed as of the effective date of this rulemaking. ( )

016. -- 999. (RESERVED)

18.02.03 – CERTIFICATE OF LIABILITY INSURANCE FOR MOTOR VEHICLES

000. LEGAL AUTHORITY.
Title 41, Chapter 49, Sections 49-1229, 49-1231, and 49-1608A, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.02.03, "Certificate of Liability Insurance for Motor Vehicles." ( )

02. Scope. To identify requirements for a certificate of liability insurance for motor vehicles pursuant to Sections 49-1229, 49-1231 and 49-1608A, Idaho Code. ( )

002. -- 010. (RESERVED)

011. CONTRACT OF INSURANCE, OR COPY THEREOF -- CERTIFICATE OF LIABILITY INSURANCE.
The original contract of liability insurance, or a copy, that demonstrates the current existence of liability insurance against loss resulting from liability imposed by law for bodily injury or death or damage to property suffered by any person caused by accident and arising out of the operation, maintenance or use of a motor vehicle or motor vehicles described, in an amount not less than prescribed by Sections 49-117(20), 49-1212, and 49-1608A, Idaho Code, and also demonstrates the current existence of any other coverage prescribed by Title 41, Idaho Code, is a form of a certificate of liability insurance prescribed as such by the Director, provided said contract of liability insurance is issued by an insurer or surety authorized to do business in this state. For the purpose of this rule a written binder qualifies as a contract of liability insurance provided it binds coverage in an amount not less than prescribed by Section 49-117(20), Idaho Code, and demonstrates the existence of any other coverage prescribed by this rule. ( )

012. MINIMUM SPECIFICATIONS FOR A CERTIFICATE OF LIABILITY INSURANCE IN LIEU OF THE CONTRACT OF INSURANCE, OR A COPY.
A document that meets the minimum specifications provided in this rule is considered a certificate of liability insurance in a form prescribed by the Director, which is acceptable in lieu of an original contract of liability insurance or a copy, demonstrating the current existence of liability insurance as described in Section 011 of this rule. The minimum requirements of a document considered a certificate of liability insurance, or a copy are: ( )

01. Individual-Owned Motor Vehicles. ( )

a. The document identifies the insurer or surety company authorized to do business in this state. ( )

b. The document provides the name and address of the owner of the insured motor vehicle. ( )

c. The document describes the motor vehicle including identification number, the last three digits of the vehicle identification number, or the words "all owned vehicles" if more than one vehicle is insured. ( )

d. The document shows the effective date the liability insurance coverage begins. ( )

e. The document may show "Certificate of Liability Insurance" or "Liability Insurance Identification Card." The words "State of Idaho" may be added to the title at the insurer's option. ( )

f. The document may show the date the liability insurance coverage ceases, or may state "not valid beyond _____," provided the phrase is completed to indicate termination of coverage at the end of a fixed period, or "not valid for more than one year," or "continuous until cancelled." ( )

g. The number of the insurance policy or the document is suggested, but optional. ( )

h. The sentence "KEEP THIS CERTIFICATE IN YOUR AUTOMOBILE AT ALL TIMES" is suggested, but optional. ( )

02. Dealer and Manufacturer Vehicles. ( )

a. The document identifies the insurer or surety company authorized to do business in this state. ( )

b. The document provides the name and address of the dealership and identifies the owner(s) (name(s) of dealer, partners, corporation or LLC members) of the insured motor vehicle. ( )

c. The document shows the effective date the liability insurance coverage begins. ( )

d. The document may show "Certificate of Liability Insurance" or "Liability Insurance Identification Card." The words "State of Idaho" may be added to the title. ( )

e. The document shows the date the liability insurance coverage ceases or may state "not valid beyond _____," provided the phrase is completed to indicate termination of coverage at the end of a fixed period, or "not valid for more than one year," or "continuous until cancelled." ( )

f. The number of the insurance policy or the document is suggested, but optional. ( )

013. EXAMPLES OF A NONEXCLUSIVE FORMAT FOR A DOCUMENT.
Examples of a nonexclusive format for a document that meets the requirements of a certificate of liability insurance in a form prescribed by the Director may be found on the Department website. ( )

014. EXAMPLE OF CERTIFICATE OF LIABILITY INSURANCE TO BE ISSUED BY THE DIRECTOR MAY BE FOUND ON THE DEPARTMENT WEBSITE.
The Director will issue a certificate of liability insurance to the owner(s) of a motor vehicle who posts an indemnity bond in a form approved by the Director pursuant to Section 49-1229(2), Idaho Code. ( )

015. -- 999. (RESERVED)

18.03.02 – LIFE SETTLEMENTS

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 19, Sections 41-211 and 41-1965, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. 18.03.02, "Life Settlements." ( )

02. Scope. This rule sets forth requirements regarding the sale and settlement of life insurance contracts where the owner of the contract is an Idaho resident. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Advertising Materials. ( )

a. Printed and published material, audio visual material, and descriptive literature of a broker or provider used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other internet displays or communications, other forms of electronic communications, billboards and similar displays; ( )

b. Descriptive literature and sales aids of all kinds issued by a provider 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 ( )

c. Prepared sales talks, presentations and material for use by providers and brokers. ( )

02. Affiliation. Any contractual relationship outside of the proposed life settlement contract, any ownership interest or relation, any familial relation, an employment relation, any relationship creating financial dependency, any arrangement that provides one party the ability to control or influence the actions of another party, or any other arrangement or relationship that might reasonably result in parties treating one another in a less than arm's length manner. ( )

03. Operating as a Broker. As defined in Section 41-1951(6), Idaho Code. ( )

04. Operating as a Provider. As defined in Section 41-1951(8), Idaho Code. ( )

011. REGISTRATION TO OPERATE AS LIFE SETTLEMENT PROVIDER OR LIFE SETTLEMENT BROKER.

01. Registration. Not later than ten (10) days after first operating as a provider or broker a person will notify the Director that they are acting as a provider or broker by registering with the Department and paying applicable fees as set forth at IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges". Registration includes information as prescribed by the Director along with a certification from the applicant that they have read and familiarized themselves with the requirements of Sections 41-1950 through 41-1965, Idaho Code, and these rules. ( )

02. Renewal of Registration. Registration as a broker or provider continues until the next renewal date of the person's producer license. If the initial registration takes place within ninety (90) calendar days from the producer license expiration date, registration will continue until the following producer license renewal date. Registration may be renewed by payment of the applicable renewal fee as set forth at IDAPA 18.01.02. An insurance producer who allows their registration as a broker or provider to lapse may, within twelve (12) months from the renewal due date, reinstate the registration by paying a penalty in the amount of double the unpaid renewal fee. If a registration is allowed to lapse for more than twelve (12) months without reinstatement, a producer wishing to act a broker or provider will re-register with the Department and pay the applicable registration fee prior to operating as a broker or provider. ( )

012. FILING OF FORMS.

01. Filing of Life Settlement Contracts and Disclosure Forms. No person may use a life settlement contract or disclosure form in Idaho unless the form is first filed with the Department along with a certification that the form meets the requirements of Sections 41-1950 through 41-1965, Idaho Code. The certification will be in the form as prescribed by the Director and signed by a person registered as a provider or broker. ( )

02. Filing of Advertising Materials. No person may use advertising materials promoting or advertising the availability of life settlements or life settlement services in Idaho unless the materials are first filed with the Department. If the advertising is not in written form, a written script will be filed. All advertising relating to the business of life settlements will have a unique identifying form number in the lower left-hand corner of the advertising piece and needs to comply the following standards: ( )

a. Be truthful and not misleading in fact and implication. All information is set out conspicuously and in close conjunction with the statements and will not be minimized, rendered obscure, ambiguous, or intermingled with the context of the advertisement so as to be confusing or misleading. ( )

b. Reference the complete form number of any life settlement contract being advertised and clearly identify the full and complete name of the provider or broker using the promotional material. Advertising materials cannot use a trade name, any insurance group designation, name of the parent company of the provider or broker, name of a particular division of the provider or broker, service mark, slogan, symbol or other device which would have the capacity and tendency to mislead or deceive as to the true identity of the provider or broker without disclosing the name of the actual provider or broker using the advertising material. ( )

c. No advertisement will 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 sellers or prospective sellers as to the nature or extent of any policy benefit payable. The fact that the contract offered is made available to a prospective seller for inspection prior to consummation of the sale or an offer is made to rescind the life settlement contract if the seller is not satisfied, does not remedy misleading statements. ( )

d. Advertising materials cannot use words or phrases in a manner which exaggerates any benefits beyond the terms of the life settlement contract and fairly and accurately describe the negative features as well as the positive features of the life settlement contract and life settlement program. An advertisement cannot represent or imply that life settlements by the provider are "liberal" or "generous," or use words of similar import, or that benefits of a life settlement are or will be beyond the actual terms of the life settlement contract. ( )

e. Advertising materials cannot be designed to encourage or promote the purchase of life insurance for the purpose of transferring ownership to third party investors who lack an insurable interest in the in the life of the insured. ( )

f. An advertisement cannot create the impression directly or indirectly that a provider, a broker, its financial condition or status, a life settlement contract or program, or the payment of life settlement benefits is approved, endorsed, or accredited by any division or agency of this state or the United States Government. ( )

g. Testimonials used in advertisements needs to be genuine, represent the current opinion of the author, be applicable to the life settlement contract advertised and be accurately reproduced. A provider or broker 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. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the provider or broker, or a related entity as a stockholder, director, officer, employee, or otherwise, such fact is disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact will be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." ( )

h. The source of any statistics used in an advertisement are identified in the advertisement. ( )

03. Font Size for Printed Materials. Pertinent text of all printed materials needs to be filed with the director under the Life Settlement Act, including, but not limited to, notices, disclosure forms, contract forms, and advertising material, is to be formatted using at least a twelve (12) point font. Signature blocks, footnotes or text not relevant to the understanding of the printed material may be printed in a smaller font, but in no case smaller than a ten (10) point font. ( )

04. Disapproval of Noncompliant Forms. The Director may disapprove any form needed to be filed

pursuant to this Section if, the form does not comply with any part of Title 41, Idaho Code, or these rules, or the form is unreasonable in its terms, contrary to the interests of the public, misleading to the public, unfair to the owner, or is printed or provided in a manner making any part of the form substantially illegible. ( )

013. ANNUAL REPORTING REQUIREMENTS.
All persons registered with the Director as a provider will file an annual statement with the Director, on or before March 1st of each year. An annual report is needed regardless of whether any life settlement contracts with Idaho owners were executed during the year. ( )

014. EXAMINATION AND RECORDS.
Brokers and providers are subject to examination by the Director in accordance with Title 41, Chapter 2, Idaho Code, and pay, at the direction of the Director, the actual travel expenses, reasonable living expense allowance, and reasonable compensation incurred on account of the examination upon presentation of a detailed account of the charges and expenses. ( )

015. DISCLOSURES TO OWNER.

01. Disclosure to Owner Upon Application. A broker or provider will not provide an owner with an application for a life settlement contract unless the owner has also been provided a disclosure form containing all the information requisite by Idaho Code, 41-1956 and in substantially the same form as the sample form found on the Department website. The disclosures are provided in a separate document in at least twelve (12) point font. Each page of the disclosure document is initialed by the owner indicating that it has been received and read by the owner, and the final page is dated and signed by the owner and the broker or provider that delivered the disclosure document to the owner. ( )

02. Disclosures to Owner by Provider Upon Settlement. Prior to the time an owner signs a life settlement contract, the provider will provide the owner a disclosure form containing all the information prescribed by Idaho Code 41-1957 and in substantially the same form as the sample form found on the Department website. The disclosures may be made by a separate document or included as a part of the life settlement contract. If the disclosures are included in the life settlement contract, they are conspicuously displayed in the contract by segregating the disclosures from the rest of the contract on a separate page or as a separate section using at least twelve (12) point font and with a heading in bold font stating: "Important Disclosures Required by Law." Each disclosure page of the life settlement contract is initialed by the owner indicating that the owner has read the page. If the disclosures are provided in a separate document, each page of the document will be initialed by the owner and the final page needs to be dated and signed by the owner and the provider. ( )

03. Disclosure to Owner by Broker Upon Settlement. Prior to the time an owner signs a life settlement contract, the broker will provide the owner a disclosure form containing all the information prescribed in Idaho Code 41-1958 and in substantially the same form as the sample form found on the Department website. The disclosures may be made by a separate document or included as a part of the life settlement contract. If the disclosures are included in the life settlement contract, they are conspicuously displayed in the contract by segregating the disclosures from the rest of the contract on a separate page or as a separate section using at least twelve (12) point font, and a heading in bold font stating: "Important Disclosures Required by Law." Each disclosure page of the life settlement contract is initialed by the owner indicating that the owner has read the page. If the disclosures are provided in a separate document, each page of the document needs to be initialed by the owner and the final page dated and signed by the owner and the broker. ( )

04. Affiliations Disclosed. As a part of the disclosures in this Section, a provider discloses in writing to the owner any affiliation between the provider and the issuer of the insurance policy to be settled, and a broker discloses in writing any affiliation or contractual arrangement between the broker and any person making an offer in connection with a proposed life settlement contract. ( )

016. ADDITIONAL REQUIREMENTS.

01. Owner's Statement. ( )

a. Prior to entering into a life settlement contract, the provider obtains from each owner a written

statement in substantially the following form: "I, [owners name], have freely and voluntarily consented to the life settlement contract that accompanies this statement. I have carefully read my insurance policy that is the subject of the life settlement contract and I understand the benefits that are available under the policy. I further understand that by entering into the life settlement contract, the right to benefits under the insurance policy will be sold to another party and I, my heirs or former beneficiaries will no longer have any right to receive those policy benefits." ( )

b. If the owner has a terminal or chronic illness, the following wording is also to be included in the owner's statement: "I am currently suffering from a terminal or chronic illness that was not diagnosed until after the policy that is the subject of the life settlement contract was issued." ( )

c. The statement of the owner needs to also be acknowledged by a notary public. ( )

02. Owner's Right to Rescind Life Settlement Contract. ( )

a. The life settlement contract is to conspicuously inform the owner in bold type of at least twelve (12) point font that the owner has an absolute right to rescind a life settlement contract within twenty (20) calendar days of the date the contract is executed and sets forth the manner in which notice is given. ( )

b. Upon being informed of the owner's intention or desire to rescind a life settlement contract, the provider immediately provides the owner with a full accounting of the amount that will be repaid by the owner in to rescind the policy. The amount due includes only amounts actually paid to and received by the owner pursuant to the terms of the life settlement contract along with any premiums, loans and loan interest paid by or on behalf of the provider in connection with or as a direct consequence of the life settlement contract. An owner is not obligated to pay any financial penalties, liquidated damages or other punitive fees or charges in connection with rescission of a life settlement contract. ( )

c. Until the owner receives from the provider an accounting of the full and correct repayment amount needed to rescind the life settlement contract, a tender of payment by the owner of amounts actually received and reasonably believed to be due upon rescission will be deemed in substantial compliance with the requirement of notice and repayment of proceeds within the twenty (20) day rescission period. ( )

03. Life Settlements Occurring Within Two Years of Policy Origination. ( )

a. No broker or provider may solicit, arrange for, or enter into a life settlement contract within two (2) years of the date of issuance of the life insurance policy or certificate being settled unless one (1) or more of the conditions identified in Section 41-1961, Idaho Code, applies. If one (1) or more of the conditions is present, the provider obtains from the owner a written statement sworn before a notary public setting forth in detail the circumstances permitting the early settlement of the contract. The sworn statement also includes the following or substantially similar wording: "I hereby affirm that there was no plan or arrangement in place or under discussion, or any promises made, regarding the settlement of this life insurance policy at the time the policy was purchased." ( )

b. In addition to the sworn statement, the provider will obtain and retain as a part of its records independent documentation of the circumstances permitting early settlement of the life insurance policy along with all documentation relating to any premium financing arrangements made in connection with the policy being settled. ( )

c. The sworn statement and copies of all supporting documentation will be provided to the insurer at the time a request for verification of coverage is submitted to the insurer. A request for verification of coverage relating to a policy or certificate that has been in effect for two (2) years or less will be considered incomplete if it is not accompanied by the owner's sworn statement and supporting documentation. An insurer that determines a request for verification of coverage is incomplete will immediately inform the broker or provider in writing that the verification is incomplete and identify all items needed to complete the request. ( )

017. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 19, Idaho Code. ( )

001. PURPOSE.
To provide a comprehensive plan: for the qualification and licensing of insurers to write policies or contracts on a variable basis; for establishment of separate accounts and the investment of assets contained therein; for the filing and approval of policy and contract forms; for reports to contract holders; for the qualification, examination and licensing of agents and other persons; providing for the establishment and preservation of certain records and the establishment of other standards pertaining to the offering and sale of such contracts. ( )

002. -- 009. (RESERVED).

010. DEFINITIONS.

01. Variable Contracts. Any policy or contract that provides for insurance or 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. ( )

02. Agent. Any person, corporation, partnership, or other legal entity which under the laws of this state is licensed as a life insurance agent. ( )

03. Variable Contract Agent. An agent who sells or offers to sell any contract on a variable basis. ( )

04. Satisfactory Alternative Examination. Part I of the written examination includes any securities examination that is declared by the Director to be an equivalent examination. The following are satisfactory alternative examinations: ( )

a. The Financial Industry Regulatory Authority (FINRA), Examination for Principals, or Examination for Qualification as a Registered Representative; ( )

b. The various securities examinations needed by the New York Stock Exchange, the American Stock Exchange, or the Pacific Coast Stock Exchange; ( )

c. The Securities and Exchange Commission test given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934, as amended; ( )

d. The examination recommended for the testing of variable contract agents by the National Association of Insurance Commissioners, when adopted by the Insurance Department of any State or Territory of the United States and approved for use by such Department by the Securities and Exchange Commission; and ( )

e. Any State Securities Sales Examination accepted by the Securities and Exchange Commission. ( )

011. QUALIFICATIONS OF INSURANCE COMPANIES TO ISSUE VARIABLE CONTRACTS.

01. Parent or Affiliated Insurer. An insurer that issues variable contracts and that is a subsidiary of, or affiliated through common management or ownership with, another life insurer authorized to transact such insurance in this state meets the provisions of this Section if either it or the parent or affiliated insurer meets the provisions hereof. ( )

02. Delivery. Before any insurer delivers or issues for delivery variable contracts in this state, it will submit to the Director a general description of the kinds of variable contracts it intends to issue; ( )

012. SEPARATE ACCOUNTS.

01. Domestic Life Insurer. A domestic life insurer issuing variable contracts and establishing one (1) or more separate accounts pursuant to Sections 41-1936 and 41-734 of the Idaho Insurance Code is subject to the following provisions: ( )

a. To the extent that the company's reserve liability with regard to: (a) benefits guaranteed as to dollar

amount and duration, and (b) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability are invested in accordance with the laws of this state governing the investments of life insurance companies. ( )

b. With respect to seventy-five percent (75%) of the market value of the total assets in a separate account no insurer may 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 value, would exceed ten percent (10%) of the market value of the assets of said separate account. The Director may waive such limitation if such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this state. ( )

c. Unless otherwise permitted by law or approved by the Director, no insurer may purchase or 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 ten percent (l0%) of the total issued and outstanding voting securities of such issuer. The foregoing does not apply with respect to securities held in separate accounts with voting rights exercisable only in accordance with instructions from persons having interests in such accounts. ( )

d. The limitations provided in Subsections 012.01.b. and 012.01.c. above do 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 Subsections 012.01.b. and 012.01.c. ( )

02. Chargeability of Assets with Liabilities. That portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account is not chargeable with liabilities arising out of any other business the insurer may conduct. Notwithstanding any other provisions of law an insurer 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 insurer, 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 cannot be 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 insurer. 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. An insurer, committee, board or other body, may make such other provisions in respect to any such separate account which are appropriate to facilitate compliance with requirements of any Federal or State law, provided that the Director approves such provisions as not hazardous to the public or the company's policyholders in this state. ( )

03. Assets Equal to Reserves and Liabilities. The company will maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account. ( )

04. Officers and Directors. Rules under any provision of the Insurance Law of this state of any rule applicable to the officers and directors of insurance companies with respect to conflicts of interest also apply to members of any separate account's 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 will receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account. ( )

013. FILING OF CONTRACTS.
Each insurer will submit to the Director a copy of each prospectus adopted by it for use in conjunction with the sale of

any contract offered for sale in this state. ( )

014. CONTRACTS PROVIDING FOR VARIABLE BENEFITS.

01. Illustrations. Illustrations of benefits payable under any variable contract providing benefits payable in variable amounts cannot include projections of past investment experience into the future or attempted predictions of future investment experience. ( )

02. Payment of Periodic Stipulated Payments. No individual variable annuity contract calling for the payment of periodic stipulated payments will be delivered or issued for delivery unless it contains in substance the following provisions or provisions which are more favorable to the holders of such contracts: ( )

a. The grace period is for one (1) month, but not less than thirty (30) days, in which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract will continue in force. The contract may include a statement of the basis for determining the date that any such payment received during the period of grace is applied to produce the values under the contract; ( )

b. At any time within one (1) year from the date of default in making periodic stipulated payments to the insurer during the life of the annuitant, unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as prescribed by the contract, and payment or reinstatement of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date which the amount to cover such overdue payments and indebtedness is applied to produce the values under the contract; ( )

c. Specifying the options available in the event of default in a periodic stipulated payment, which may include an option to surrender the contract for a cash value as determined by the contract, and will include an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of such paid-up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract. ( )

03. Investment Increment Factor. Any individual variable annuity contract delivered or issued for delivery in this state will stipulate the investment increment factor to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and may guarantee that expense and/or mortality results do not adversely affect such dollar amounts. If not guaranteed, the expense and mortality factors are also to be stipulated in the contract. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable contract: ( )

a. The annual net investment increment assumption will not exceed five percent (5%), except with the approval of the Director. ( )

b. To the extent that the level of benefits may be affected by future mortality results, the mortality factor is to be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the Director, from another table. ( )

c. "Expense," as used in this subsection, may exclude part or all taxes, as stipulated in the contract. ( )

04. Reserve Liability. The reserve liability for variable contracts is to be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided, and any mortality guarantees. ( )

015. REQUISITE REPORTS.

01. Statement Reporting the Investments. Any insurer issuing individual variable contracts providing benefits in variable amounts will mail to the contract holder at least once in each contract year after the first at the last address known to the company, a statement or statements reporting the investments held in the separate account and, in the case of contracts under which payments have not yet commenced, a statement reporting as of a

date not more than four (4) months previous to the date of mailing, (a) the number of accumulation units credited to such contracts and the dollar value of a unit, or (b) the value of the contract holder's account. ( )

02. Statement of Business to Director. The insurer will submit annually to the Insurance Director a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners. ( )

016. FOREIGN INSURERS.

If the law or rule in the place of domicile of a foreign insurer provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these rules, the Director, at their discretion, may consider compliance with such law or rule as compliance with these rules. ( )

017. -- 999. (RESERVED).

18.03.04 – REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

000. LEGAL AUTHORITY.
Title 41, Chapter 13, Sections 1305 and 1327, Idaho Code. ( )

001. TITLE AND SCOPE.
This rule regulates the activities of insurers, agents and brokers with respect to the replacement of existing life insurance and annuities, and establishes minimum standards of conduct. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Conservation. Any attempt by the existing insurer or its agent or broker to dissuade a policy owner from the replacement of existing life insurance or annuity. Conservation does not include such routine administrative procedures such as late payment reminders, late payment offers or reinstatement offers. ( )

02. Direct-Response Sales. Any sale of life insurance or annuity where the insurer does not utilize an agent in the sale or delivery of the policy. ( )

03. Existing Insurer. The insurance company whose policy is or will be changed or terminated in such a manner as described in the definition of "replacement." ( )

04. Existing Life Insurance or Annuity. Any life insurance or annuity in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity that is in an unconditional refund period. ( )

05. Replacement. Any transaction by which new life insurance or a new annuity is to be purchased, and it is known or should be known to the proposing agent or broker, or to the proposing insurer if there is no agent, that existing life insurance or an annuity has been or is to be: ( )

a. Termination. Lapsed, forfeited, surrendered, or otherwise terminated. ( )

b. Conversion or Continuance. Converted to reduced paid-up insurance, continued as extended term insurance, or reduced in value by the use of nonforfeiture benefits or other policy values. ( )

c. Amendment. Amended so as to effect either a reduction in benefits or in the term for which coverage would remain in force or for which benefits would be paid. ( )

d. Reissuance. Reissued with any reduction in cash value. ( )

e. Loans. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five percent (25%) of the loan value set forth in the policy. ( )

06. Replacing Insurer. The insurance company that issues or proposes to issue a new policy or contract which is a replacement of existing life insurance or annuity. ( )

011. EXEMPTIONS.
Unless specifically included, this rule does not apply to transactions involving: ( )

01. Credit Life Insurance. ( )

02. Group Life Insurance or Group Annuities. ( )

03. Existing Insurer. An application to the insurer that issued the existing life insurance and a contractual change or conversion privilege being exercised; ( )

04. Binding or Conditional Receipt Issued by Same Company. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company. ( )

05. Common Ownership or Control. Transactions where the replacing insurer and the existing insurer are the same, or are subsidiaries or affiliates under common ownership or control. Provided, however, agents

or brokers proposing replacement will comply with the requirements of Subsection 012.01. ( )

012. DUTIES OF AGENTS AND BROKERS.

01. Statement Submitted to Insurer. Each agent or broker who initiates the application submits to the insurer to which an application for life insurance or annuity is presented, with or as part of each application: ( )

a. A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction; and ( )

b. A signed statement as to whether the agent or broker knows replacement is or may be involved in the transaction. ( )

02. Notice to Applicant. Where a replacement is involved, the agent or broker will: ( )

a. Present to the applicant, not later than at the time of taking the application, a "Notice Regarding Replacement" in the form as described on the DOI website, or other substantially similar form approved by the Director. The notice is signed by both the applicant and the agent or broker and left with the applicant. ( )

b. Obtain with or as part of each application a list of all existing life insurance and/or annuities replaced and properly identified by name of insurer, the insured and contract number. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, is listed. ( )

c. Leave with the applicant the original or a copy of written or printed communications used for presentation to the applicant. ( )

d. Submit to the replacing insurer with the application a copy of the replacement notice provided pursuant to Subsection 012.02.a. ( )

03. Conservation. Each agent or broker who uses written or printed communications in a conservation will leave with the applicant the original or a copy of such materials used. ( )

013. DUTIES OF ALL INSURERS.
Each insurer will: ( )

01. Notice to Representatives of Rule. Informs its field representatives or other personnel responsible for compliance with this rule of the requirements of this rule. ( )

02. Application. Requires with or as a part of each completed application for life insurance or annuity a statement signed by the applicant as to whether such proposed insurance or annuity will replace existing life insurance or annuity. ( )

014. DUTIES OF INSURERS THAT USE AGENTS OR BROKERS.
Each insurer that uses an agent or broker in a life insurance or annuity sale: ( )

01. Statement by Agent or Broker. With or as part of each completed application for life insurance or annuity, obtains a statement signed by the agent or broker as to whether he or she knows if replacement is involved in the transaction. ( )

02. Replacement Notice and List of Existing Insurance. Where a replacement is involved: ( )

a. With the application for life insurance or annuity, obtains a list of all of the applicant's existing life insurance or annuities replaced and a copy of the replacement notice provided the applicant pursuant to Section 012. Such existing life insurance or annuity is identified by name of insurer, insured and contract number. If a number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, is listed.

( )

b. Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained pursuant to Subsection 014.02.a. and a policy summary or ledger statement containing policy data on the proposed life insurance or annuity as prescribed by the model life insurance solicitation rule and/or the model annuity and deposit fund disclosure rule. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary or ledger statement. This written communication is made in five (5) working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner. ( )

c. Each existing insurer, agent, or broker that undertakes a conservation furnishes the policy owner with a policy summary for the existing life insurance or a ledger statement containing policy data on the existing policy and/or annuity within twenty (20) days from the date the written communication and the materials described in Subsections 014.02.a. and 014.02.b. are received. Such policy summary or ledger statement is completed in accordance with information relating to premiums, cash values, death benefits and dividends, if any, and is computed from the current policy year of the existing life insurance. The policy summary includes the amount of any outstanding indebtedness, the sum of any dividend accumulations or additions, and may include any other information that is not in violation of any rule or statute. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary. When annuities are involved, the disclosure information is requisite in a contract summary under the annuity and deposit fund disclosure rule. The replacing insurer may request the existing insurer to furnish it with a copy of the summaries. ( )

03. Maintenance of Records. The replacing insurer maintains evidence of the "Notice Regarding Replacement," the policy summary, the contract summary and any ledger statements used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced. The existing insurer maintains evidence of policy summaries, contract summaries or ledger statements used in any conservation. Evidence that all requirements were met are maintained for at least three (3) years or until the conclusion of the next succeeding regular examination by the insurance department of its state of domicile, whichever is later. ( )

04. Refund. The replacing insurer provides in its policy or in a separate written notice which is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised in a period of twenty (20) days commencing from the date of delivery of the policy. ( )

015. DUTIES OF INSURERS WITH RESPECT TO DIRECT RESPONSE SALES.

01. Insurer Did Not Propose Replacement. If in the solicitation of a direct response sale, the insurer did not propose the replacement, and a replacement is involved, the insurer will propose to send to the applicant with the policy a Replacement Notice as described on the DOI website or other substantially similar form approved by the Director. ( )

02. Insurer Proposed Replacement. If the insurer proposed the replacement it will: ( )

a. Provide to applicants or prospective applicants with or as part of the application a replacement notice as described on the DOI website or other substantially similar form approved by the Director. ( )

b. Request from the applicant with or as part of the application, a list of all existing life insurance or annuities replaced and properly identified by name of insurer and insured. ( )

c. Comply with the requirements of Subsection 014.02.b., if the applicant furnishes the names of the existing insurers, and the requirements of Subsection 014.03, except that it need not maintain a replacement register. ( )

016. PENALTIES.

Failure by an insurer, agent, representative, officer, or employee of such insurer to comply with the requirements of this rule is subject to such penalties as may be appropriate under the Idaho Code, including Section 41-1327, Idaho Code. ( )

017. -- 999. (RESERVED)

18.04.03 – ADVERTISEMENT OF DISABILITY (ACCIDENT AND SICKNESS) INSURANCE

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 13, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.03, "Advertisement of Disability (Accident and Sickness) Insurance." ( )

02. Scope. To protect consumers by assuring truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance, including Medicare supplement accident and sickness insurance and long-term care insurance. This is accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability (accident and sickness) insurance in a manner that prevents unfair competition among insurers and promotes an accurate presentation and description to the insurance buying public. ( )

002. APPLICABILITY.

01. Disability and Medicare Supplement Insurance. Any disability (accident and sickness) insurance "advertisement," including Medicare supplement and long-term care insurance "advertisement," as that term is 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 or producer. ( )

02. Control over Advertisement. Every insurer will 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 created, designed or presented, are the responsibility of the insurer whose policies are so advertised. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Advertisement. Includes: ( )

a. Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other internet displays or communications, other forms of electronic communications, billboards and similar displays; ( )

b. Descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the insurance buying public; and ( )

c. Prepared sales talks, presentations and material for use by producers whether prepared by the insurer or the producer. ( )

02. Policy. Any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that 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. The term includes contracts for Medicare supplement insurance and long-term care insurance. ( )

03. Insurer. Includes any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity 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. ( )

04. Exception. Any provision in a policy where coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy. ( )

05. Reduction. Any provision that 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 payable had such reduction not been used. ( )

06. Limitation. Any provision that restricts coverage under the policy other than an exception or a reduction. ( )

011. METHOD OF DISCLOSURE OF REQUISITE INFORMATION.
All information needed to be disclosed by these rules will be set out conspicuously and closely associated with the statements to which such information relates or under appropriate captions of such prominence that it will 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. ( )

012. FORM AND CONTENT OF ADVERTISEMENTS.
The format and content of an advertisement of an accident or sickness insurance policy will be sufficiently complete, not misleading, and clear to avoid deception. ( )

013. ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE.

01. Prohibitions. Deceptive words, phrases or illustrations banned: ( )

a. No advertisement will contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "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" or similar words and phrases, in a manner that exaggerates any benefits beyond the terms of the policy. ( )

b. An advertisement will not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit. Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions should fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered. ( )

c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility will use words or phrases that 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. ( )

d. No advertisement of a hospital or other similar facility benefit will 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. When the policy contains a limit on the number of days of coverage provided, such limit needs to appear in the advertisement. ( )

e. No advertisement of a policy covering only one (1) disease or a list of specified diseases will imply coverage beyond the terms of the policy. ( )

f. An advertisement for a policy providing benefits for specified illnesses only, or for specified accidents only, will clearly and conspicuously in prominent type, state the limited nature of the policy. The statement will be 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." ( )

g. No advertisement of a direct response insurance product will 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. ( )

h. No advertisement will contain or use words or phrases such as, "Medicare supplement"; "Medigap"; "this policy will help fill some of the gaps that Medicare leaves out"; or similar words and phrases, unless the policy is issued in compliance with IDAPA 18.04.10. ( )

i. An advertisement will clearly state the type of insurance coverage being offered. ( )

02. Exceptions, Reductions and Limitations. ( )

a. 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 1oss for which such benefit is payable, it will also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. ( )

b. 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 that is subject to the requirements of the preceding paragraph will disclose the existence of such periods. ( )

c. An advertisement will not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to describe the applicability of any exceptions and reductions. ( )

03. Pre-Existing Conditions. ( )

a. An advertisement subject to the requirements of Subsection 013.02 will, 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 term "pre-existing condition" without an appropriate definition or description will not be used. ( )

b. When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy will 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 does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement will disclose that a medical examination is needed. ( )

c. 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 will contain a question or statement that reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. ( )

014. NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLATION 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 will disclose the provisions relating to renewability, cancellation and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner that will not minimize or render obscure the qualifying conditions. ( )

015. TESTIMONIALS OR ENDORSEMENTS BY THIRD PARTIES.

01. Testimonials. Testimonials used in advertisements will 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 this chapter. ( )

02. Disclosure of Financial Interest. 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 will be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact will be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This chapter does not require disclosure of union "scale" wages set 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 requires disclosure of such compensation. ( )

03. Limitations and Restrictions. An advertisement will 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 will be disclosed in the advertisement. ( )

04. Retention of Data. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information is retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. ( )

016. USE OF STATISTICS.

01. Requests for Use of Statistical Information. 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 cannot use irrelevant facts, and cannot be used unless it accurately reflects all relevant facts. Such an advertisement will not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans will specifically so state. ( )

02. Restrictions on Representations. An advertisement will 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 cannot be used. ( )

03. Source of Statistics. The source of any statistics used in an advertisement will be identified in such advertisement. ( )

017. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES.

01. Disclosure Requirements. When a choice of the amount of benefits is referred to, an advertisement will 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. ( )

02. Disclosure Based on Combination of Policies. When an advertisement refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement will disclose that such benefits are provided only through a combination of such policies. ( )

018. DISPARAGING COMPARISONS AND STATEMENTS.
An advertisement will not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and will not disparage competitors, their policies, services or business methods, and will not disparage or unfairly minimize competing methods of marketing insurance. ( )

019. JURISDICTION LICENSING AND STATUS OF INSURER.

01. Restrictions on Licensing Jurisdiction. An advertisement intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed will not imply licensing beyond those limits. ( )

02. Restrictions on Endorsements. An advertisement will 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. ( )

020. IDENTITY OF INSURER.

01. Name of Insurer to Be Identified. The name of the actual insurer is clearly identified and the

policy or policies advertised is identified by form number or otherwise described. An advertisement will 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 that, without disclosing the name of the actual insurer. ( )

02. Identity of Insurer Not to Be Misrepresented. No advertisement can use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combinations of words, symbols, or physical materials used by agencies of the federal government or of this state, or 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. ( )

021. GROUP OR QUASI-GROUP IMPLICATIONS.

An advertisement of a particular policy will 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. ( )

022. INTRODUCTORY, INITIAL OR SPECIAL OFFERS.

01. Restrictions on Introductory, Initial or Special Offers. ( )

a. An advertisement of an individual policy will not 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 cannot contain phrases describing an enrollment period as "special," "limited," or similar words. ( )

b. An enrollment period during which a particular insurance product may be purchased on an individual basis cannot be offered within this state unless there has been a lapse of not less than three (3) months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement will indicate the date by which the applicant need mail the application, which is not less than ten (10) days and not more than forty (40) days from the date that such enrollment period is advertised for the first time. This chapter applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one (1) insurer. It is inapplicable to solicitations of employees or members of a particular group or association that would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one (1) insurer" includes all the affiliated companies of a group of insurance companies under common management or control. ( )

c. This chapter 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. ( )

d. The phrase "a particular insurance product" in paragraph(s) of this Section means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; and increase or decrease in the dollar amounts of benefits; and increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy will not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods. ( )

02. Restrictions on Reduced Initial 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 will not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium. ( )

03. Restriction on Special Awards. Special awards, such as a "safe drivers' award" will not be used in connection with advertisements of accident or accident and sickness insurance. ( )

023. STATEMENTS ABOUT AN INSURER.

An advertisement will not contain statements that 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 will 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. ( )

024. ENFORCEMENT PROCEDURES.
Each insurer will 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 that will indicate the manner and extent of distribution and the form number of any policy advertised. Such file is subject to regular and periodical inspection by this Department. All such advertisements will be maintained in said file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever period is longer. ( )

025. FILING FOR PRIOR REVIEW.
The Director may, at their discretion, require the filing of any accident and sickness insurance advertising material for review prior to use. ( )

026. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 39, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.04, "The Managed Care Reform Act Rule." ( )

02. Scope. The Act and this chapter define procedures to be followed in establishing and operating a Managed Care Organization. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Balance Billing. The practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. ( )

02. MCO. Managed Care Organizations is abbreviated to MCO in this rule. ( )

03. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or authorized to furnish health care services. ( )

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority. Any person offering a managed care plan on a predetermined and prepaid basis is transacting the business of insurance and needs to be authorized under a Certificate of Authority issued by the Director of Insurance. ( )

02. Application Requirements. The application for a Certificate of Authority will include the affidavits, statements, and other information as enumerated in Idaho Code, Sections 41-319, 41-3904, 41-3905, and 41-3906. After receiving these completed documents, the Director has the authority to request any supplemental information before final approval or disapproval is given. ( )

03. Capital Surplus and Deposit Requirements. ( )

a. The Director has established the following minimum capital fund requirements as per Section 41-3905(8), Idaho Code, based on the number of enrolled members:

Enrolled Members	Capital Funds
0-100	$200,000
101-300	$300,000
301-500	$400,000
501-700	$500,000
701-1,000	$1,000,000
1,001-2,000	$1,500,000
2,001-3,000	$2,000,000

( )

b. In no event will the organization's capital funds be less than the following:

One year after the organization becomes subject to the Act	$1,000,000
Two years after the date the organization becomes subject to the Act	$1,500,000
Three years after the date the organization becomes subject to the Act	$2,000,000

( )

c. Immediately upon becoming subject to the Act, the MCO's minimum statutory deposit requirements is calculated as fifty percent (50%) of the amount of the organization's Capital funds as calculated above up to a maximum of one million dollars ($1,000,000), but not less than two hundred thousand dollars ($200,000). The amount of the deposit so held by the Department is adjusted based on the organization's December 31st and June 30th financial statement filings each year. In no event will the minimum prescribed statutory deposit amount be reduced. Upon notification by the Department of the necessary increase in the deposit amount, the organization will have no more than thirty (30) days to come into compliance with the prescribed amount. Failure to increase the deposit as prescribed will subject the organization to suspension or revocation of its certificate of authority pursuant to Section 41-326, Idaho Code. ( )

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Requisite. In accordance with Section 41-3904, Idaho Code, a proposed MCO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed managed care services. ( )

02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed MCO will submit its request for permission to the Director in writing, with copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. ( )

03. Methods of Solicitation. Advertising and solicitation materials used by a proposed MCO need to meet the following minimum requirements: ( )

a. The prospective enrollee will clearly be advised that: ( )

i. The proposed MCO is not as yet authorized to offer health care services in this state; ( )

ii. Coverage for health care services is not being provided at the time of the solicitation; ( )

iii. The solicitation is not a guarantee that any services will be provided at a future date. ( )

b. The format and content of any material offered will conform with the MCO Act. Such material will contain but not be limited to the following information: ( )

i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled; ( )

ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; ( )

iii. The predetermined periodic rate of payment for the proposed services; ( )

iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. ( )

c. No person will solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO. ( )

013. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.
The annual disclosure material prescribed to be filed with the Director pursuant to Section 41-3914, Idaho Code, is filed with the reports to the Director on or before March 1 each year. ( )

014. ANNUAL REPORT TO THE DIRECTOR.
In accordance with Sections 41-3910 and 41-335, Idaho Code, every managed care organization will annually on or before the first day of March, file with the Director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise prescribed by the Director, the statement is to be

prepared in accordance with the annual statement instructions and the accounting practices and procedures manual adopted by the National Association of Insurance Commissioners (NAIC) and is to be submitted on the NAIC annual convention blank form. The managed care organization will also file its annual audited financial report in accordance with IDAPA 18.07.04, "Annual Audited Financial Reports." ( )

015. PERSONNEL AND FACILITIES LISTING.

01. Current Listing. The MCO will at all times keep a current list of all personnel, providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list is to be made available to the Director upon request. ( )

02. Allowable Expense -- No Balance Billing. No MCO provider or other provider accepting a referral from an MCO, who treats or provides services to an individual covered by the MCO, may charge to or collect from any member or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the MCO or by the administrator for the MCO. Nothing in this section prevents the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. ( )

03. Procedures for Basic Care and Referrals. The MCO will provide basic health care to enrollees through an organized system of health care providers. In plans in which referrals to specialty physicians and ancillary services are prescribed, the MCO provider or the MCO will initiate the referrals. The MCO will inform its providers of their responsibility to provide written referrals and any specific procedures that need to be followed in providing referrals, including prohibition of balance billing. ( )

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, will arrange for covered health care services, including referrals to providers within the organized system of health care providers and noncontracting providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters. ( )

05. Out of Network Services. In the case of provider care which is delivered outside of the organized system of health care providers or defined referral system, the MCO will alert those covered under health benefit plans to the fact that providers which are not MCO providers, or have not accepted written referrals, may balance bill the customer for amounts above the MCO's maximum allowance. Consumers should be encouraged to discuss the issue with their providers ( )

016. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.05, "Self-Funded Health Care Plans Rule." ( )

02. Scope. This rule supplements the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. "All Contributions to Be Paid in Advance." All contributions are to be paid in advance of the period of time for which the contribution is made. ( )

02. "Deposited in and Disbursed from a Trust Fund." All contributions based on calculated rates in accordance with Section 028 of this rule are deposited into the trust fund and all expenses are paid out of the trust fund. ( )

011. -- 020. (RESERVED)

021. QUALIFICATION OF PLAN.
In order for a plan to qualify under Title 41, Chapter 40, Idaho Code, the plan's trust will be established by agreement between the employer or employers or a postsecondary education institution and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the employer or employers or to students of the postsecondary educational institution. ( )

022. REGISTRATION.

01. Registration Requisite. No self-funded plan, unless exempted from registration by Section 41-4003, Idaho Code, will be organized and permitted to operate in the state of Idaho without securing a Certificate of Registration from the Director. ( )

02. Specific Plans. Any plans covering the employees of a common employer are a single plan in respect to the exemption for registration allowed in Section 41-4003, Idaho Code. Any combinations of plans under the effective control of a single administrator, trustee, and/or employer, or group of administrators, trustees and/or employers utilizing or attempting to utilize the exempt dollar amounts permitted under Section 41-4003, Idaho Code in order to avoid registration of any such plans are deemed to be contrary to the intent of Title 41, Chapter 40, Idaho Code, and are expressly banned by this rule. ( )

03. Beneficiary Within State. Registration is mandatory of plans that cover any beneficiary working or residing within this state, unless the plans are otherwise exempted by Section 41-4003(2), Idaho Code. ( )

023. (RESERVED)

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.
The Director may make an investigation of matters accompanying the application for registration including an examination specified in Section 41-4013, Idaho Code. Costs of any investigation or examination, or both, will be borne by the trust fund of the plan. ( )

025. CONTRIBUTIONS RECEIVABLE.
The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. ( )

026. TRUST FUND RESERVES AND SURPLUS.

01. Reserve Requirements. The trust fund of the plan is to continuously maintain reserves sufficient, as certified by a qualified actuary as being necessary, to fully fund payment of all benefits in effect at the time a claim arises. This reserve needs to adequately provide for all reasonably estimated future claim payments, adjustment

expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any. ( )

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits cannot be less than the Minimum Reserve Standards for Group Health Insurance Contracts set forth the in the NAIC's Accounting Practices and Procedures Manual unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified. ( )

03. Certification by Actuary. Reserves needs to be certified annually by a qualified actuary. Such certification needs to be accompanied by a statement describing bases used in reserve determination. The certification will be in a form acceptable to the Director. ( )

04. Insolvent Condition. If determination of surplus reveals a deficiency in surplus, the Director may allow the plan up to ninety (90) days to accumulate prescribed surplus. The plan is deemed insolvent when it is either unable to pay its obligations or its assets do not exceed all its liabilities, including prescribed reserves. ( )

027. BONDING.

01. Certified Copy of Bond. The plan will submit to the Director a certified copy of the fidelity bond or equivalent coverage, as prescribed under Section 41-4014(3), Idaho Code. ( )

02. Scope of Coverage. The fidelity bond or equivalent coverage will cover every trustee, officer, director, and employee of the plan. ( )

03. Cancellation of Bond Requirements. The fidelity bond or equivalent coverage needs to contain language stating that it is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. A copy of any notice cancelling a bond prescribed under Title 41, Chapter 40, Idaho Code, is to be forwarded to the Director by the surety at the same time it is forwarded to the trustee. ( )

04. Third Party Administrator. Any party that provides any one of the following services to the plan needs to be licensed as a third party administrator: ( )

a. Directly or indirectly underwrites; ( )

b. Collects or handles charges or contributions; or ( )

c. Adjusts or settles claims on members or beneficiaries of the plan. ( )

028. CONTRIBUTION RATES.

01. Contribution Rate Calculation. Contribution rates will be calculated at least annually by a qualified actuary. The contribution rate calculations should break down and designate the rate for the employer and the rate per employee, or the rate for the postsecondary educational institution and the rate per student. ( )

02. Employer Contributions. Employer contributions will be based on filed rates, paid in advance on a periodic basis during the period of coverage or at the beginning of the period of coverage. ( )

03. Annual Filing of Rates. The annual filing of rates with the Director will include a breakdown as prescribed under Subsection 028.01. ( )

029. CONTRACTS AND SERVICES.

01. Affiliated Contracts. All contracts for goods or services provided to the plan by any plan sponsor, employer, third party administrator, or other affiliated entity or employee or agent thereof, will be in writing, setting forth in detail the rights and duties of each party to the writing; regardless of whether compensation, fees, or other consideration is paid or exchanged directly or indirectly. ( )

02. Contracts for Services. All contracts for services directly affecting the plan including, but not limited to, accounting services, legal services, custodial agreements, and agreements for lease, rent, or insurance coverage to be performed or entered into on behalf of the plan will be agreed to by the board of trustees and the other party. ( )

03. Recordkeeping and Writing. Contracts and agreements valued at greater than five hundred dollars ($500.00) entered into by the plan, will be in writing and approved by resolution of the board of trustees, and placed in the minutes and records of the plan. ( )

04. Fiduciary Duty. By entering into contracts and agreements, the trustees are not permitted to transfer or avoid their statutory fiduciary responsibilities. ( )

030. RECORDS.

01. Board Actions. Any and all acts, resolutions, appointments, or delegations, or other decisions of the board of trustees will be in writing and placed in the minutes and records of the plan. ( )

02. Complete Records. The full and accurate records and accounts of the plan include, but are not limited to, minutes of the meetings of the board of trustees that document the acts, resolutions, appointments or delegations of the trustees; any and all correspondence between the board of trustees and contractors; accounting and actuarial records; and any and all records, correspondence, minutes, or statements as prescribed by law or the trust agreement. ( )

031. ANNUAL STATEMENT.
The trustee will file an annual statement within ninety (90) days after the close of each fiscal year of the Plan and at such other time as may be determined by the Director. A quarterly statement will be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director. ( )

032. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.06, "Governmental Self-Funded Employee Health Care Plans Rule." ( )

02. Scope. The purpose of this rule is to supplement the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing: ( )

a. Dates of application for registration; ( )

b. Requirements for application for registration; ( )

c. Rules regarding investigation of applications; ( )

d. Definition of needed liabilities; and establishment of reserve bases; and ( )

e. To provide an effective date. ( )

002. -- 020. (RESERVED)

021. QUALIFICATION OF PLAN.
In order to qualify under Title 41, Chapter 41, Idaho Code, the plan's trust needs to be established by agreement between the public agency employers or joint powers entity and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the public agency employer or employers. ( )

022. REGISTRATION.

01. Registration Requisite. No joint public agency self-funded plan, unless exempted from registration by Section 41-4103, Idaho Code, will be organized and permitted to operate in the state of Idaho without securing a certificate of registration from the Director of insurance. ( )

02. Beneficiary Within State. Registration is mandatory of plans that cover any beneficiary working or residing within this state, unless the plans are exempted by Section 41-4103, Idaho Code. ( )

023. APPLICATION FOR REGISTRATION.

01. Application. The application needs to include each of the requirements set out in Section 41-4105, Idaho Code. The projected income and disbursement statement referenced in Section 41-4105(2)(d), Idaho Code, needs to be certified by an actuary meeting the qualifications of Section 41-4105(2)(d), Idaho Code, and accompanied by a description of assumptions used in projecting income and disbursements together with bases used to estimate amounts reserved for claims. ( )

02. Joint Powers Agreement. The joint powers agreement needs to comply with Title 41, Chapter 41 and, to the extent not in conflict with Title 41, the joint powers agreement needs to also comply with Title 67, Chapter 23, Idaho Code. The joint powers agreement needs to contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. ( )

03. Trust Agreement. ( )

a. The trust agreement will comply with Title 41, Chapter 41, Idaho Code, and, to the extent not in conflict with Title 41, the trust agreement needs to also comply with Title 68, Idaho Code, and Title 15, Chapter 7, Idaho Code. The trust agreement will contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. ( )

b. The term irrevocable as used in Section 41-4104(1), Idaho Code, means that the plan sponsor cannot retain a power to alter, amend, revoke or terminate the transfer in trust. The trustee may, pursuant to the terms of the trust agreement, amend the terms of the trust agreement for the purpose of complying with applicable law. ( )

04. Biographical Affidavit. The application needs to be accompanied by a biographical affidavit for each trustee on a form acceptable to Director. ( )

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.
The Director may make an investigation of matters accompanying the application for registration as deemed necessary including an examination specified in Section 41-4113, Idaho Code. ( )

025. CONTRIBUTIONS RECEIVABLE.
The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. ( )

026. TRUST FUND RESERVES.

01. Reserve Requirements. The trust fund of a plan needs to continuously maintain reserves, pursuant to Section 41-4110, Idaho Code, from inception of the plan, sufficient to fully fund payment of all benefits at the time a claim arises. This reserve needs to adequately provide for all reasonably estimated future claim payments, adjustment expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any. ( )

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits cannot be less than reserves determined by the Minimum Reserve Standards for Group Health Insurance Contracts set forth the in the NAIC's Accounting Practices and Procedures Manual unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified. ( )

03. Certification by Actuary. Reserves needs to be certified annually by an actuary who meets the requirements of Section 41-4105(2)(d), Idaho Code, and such certification needs to be accompanied by a statement describing bases used in reserve determination. The certification will be in a form acceptable to the Director.
( )

04. Insolvent Condition. ( )

a. Insolvency means that the plan is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities, including needed reserves. ( )

b. If the determination of reserves reveals an insolvent condition, the Director may allow the plan a period of time not exceeding ninety (90) days to accumulate needed reserves. ( )

027. BONDING OR DISHONESTY INSURANCE.

01. Certified Copy of Bond. A certified copy of the fidelity bond or dishonesty policy, as prescribed under Section 41-4114(3), Idaho Code, will be furnished to the Director by the plan. ( )

02. Cancellation of Bond Requirements. The bond or dishonesty policy will contain language stating that the bond or policy is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. A copy of any notice cancelling a bond or dishonesty policy prescribed under Chapter 41 is to be forwarded to the Director by the surety or policy provider at the same time it is forwarded to the board.
( )

028. ANNUAL STATEMENT.
The trustee will file an annual statement within ninety (90) days after the close of each fiscal year of the plan and at such other time as may be determined by the Director. A quarterly statement will be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director. ( )

029. -- 999. (RESERVED)

18.04.08 – INDIVIDUAL AND GROUP SUPPLEMENTARY DISABILITY INSURANCE MINIMUM STANDARDS RULE

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 42, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.08, "Individual and Group Supplementary Disability Insurance Minimum Standards Rule." ( )

02. Purpose. The purpose of this chapter is to implement Title 41, Chapters 21, 22, 34, and 42, Idaho Code, to standardize and simplify the terms and coverages of individual and group supplementary disability insurance, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims, and to provide for full disclosure in the marketing and sale of such insurance. ( )

03. Applicability and Scope. This chapter applies to all individual and group policies and certificates providing hospital confinement indemnity, disability income protection, accident only, specified disease, specified accident, or limited benefit health coverage, referred to collectively in this chapter as "supplementary disability insurance," offered, delivered, issued for delivery, or renewed in this state or to a resident of this state, unless specifically exempted. ( )

a. This chapter applies to dental plans and vision plans only as specified. ( )

b. This chapter applies to group supplementary plans whether issued to supplement a group health benefit plan, or as a supplementary plan that pays benefits regardless of other coverage. ( )

c. This chapter does not apply to: ( )

i. Individual policies or contracts issued pursuant to a conversion privilege under a group policy or certificate. ( )

ii. Policies issued to employees or members as additions to franchise plans. ( )

iii. Medicare supplement policies subject to Title 41, Chapter 44, Idaho Code, Medicare Supplement Insurance Minimum Standards. ( )

iv. Long-term care insurance policies subject to Title 41, Chapter 46, Idaho Code, Long Term Care Insurance. ( )

v. Civilian Health and Medical Program of the Uniformed Services, Title 10, Chapter 55, of the United States Code, (CHAMPUS) supplement insurance policies. ( )

vi. Individual or group major medical expense coverage, including short-term coverage. ( )

002. INCORPORATION BY REFERENCE.

01. Copies. May be obtained from the Idaho Department of Insurance. ( )

02. Documents Incorporated by Reference. The following Outlines of Coverage and notices are incorporated by reference from the April 1999 version of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act: ( )

a. Hospital Confinement Indemnity Coverage. ( )

b. Disability Income Protection Coverage. ( )

c. Accident Only Coverage. ( )

d. Specified Disease. ( )

e. Specified Accident. ( )

f. Limited Benefit Health Coverage. ( )

g. Dental Plans. ( )

h. Vision Plans. ( )

i. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (direct sales). ( )

j. Notice to Applicant Regarding Placement of Accident and Sickness Insurance (other than direct sales). ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Accident Only Coverage. "Accident Only Coverage" means a policy or certificate that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by an accident, and does not provide coverage for non-accidents. ( )

02. Dental Coverage. "Dental Coverage" means a policy or certificate that primarily provides benefits for dental expenses. ( )

03. Disability Income Protection Coverage. "Disability Income Protection Coverage" means a policy or certificate that 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 of both. ( )

04. Hospital Confinement Indemnity Coverage. "Hospital Confinement Indemnity Coverage" means a policy or certificate of accident and sickness insurance that provides daily benefits for hospital confinement on an indemnity basis, meaning the benefit is a fixed dollar amount per day of confinement, regardless of the expenses incurred. ( )

05. Limited Benefit Health Coverage. "Limited Benefit Health Coverage" means a policy or certificate that provides benefits that are less than the minimum standards under Sections 035 through 039 of this chapter. ( )

06. Major Medical Expense Coverage. "Major Medical Expense Coverage" means a policy of accident and sickness insurance that provides hospital, medical and surgical expense coverage. ( )

07. Specified Accident Coverage. "Specified Accident Coverage" means a policy or certificate that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the coverage for accidental death or accidental death and dismemberment combined. ( )

08. Specified Disease Coverage. "Specified Disease Coverage" means a policy or certificate that pays benefits only after the diagnosis of a specifically named disease or diseases. ( )

09. Vision Coverage. "Vision Coverage" means a policy or certificate that primarily provides benefits for vision expenses. ( )

011. POLICY DEFINITIONS AND TERMS.
Except as provided in this chapter, an insurance policy or certificate to which this chapter applies will not include definitions more restrictive than the following: ( )

01. Accident. "Accident," "accidental injury," and "accidental" is to employ "result" language and does 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. ( )

a. "Injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. ( )

b. It may exclude injuries for which benefits are provided: ( )

i. Under workers' compensation, employers' liability, or similar law; or ( )

ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or ( )

iii. For injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. ( )

02. Convalescent Nursing Home. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" is to be defined in relation to its status, facility and available services. ( )

a. Such home or facility is to: ( )

i. Be operated pursuant to law; ( )

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; ( )

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; ( )

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and ( )

v. Maintain a daily medical record of each patient. ( )

b. The definition of the home or facility may provide that the term will not be inclusive of: ( )

i. A home, facility or part of a home or facility used primarily for rest; ( )

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or ( )

iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care. ( )

03. Home Health Care Agency. "Home health care agency" means an agency approved under Medicare, or that is licensed to provide home health care under applicable state law, or that meets all of the following requirements: ( )

a. It is primarily engaged in providing home health care services; ( )

b. Its policies are established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse); ( )

c. A physician or a registered nurse provides supervision of home health care services; ( )

d. It maintains clinical records on all patients; and ( )

e. It has a full-time administrator. ( )

04. Hospice. "Hospice" means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: ( )

a. For terminally ill patients whose life expectancy is less than six (6) months; ( )

b. Provided on an inpatient or outpatient basis; and ( )

c. Directed by a physician. ( )

05. Hospital. "Hospital" is to be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation of Rehabilitation Facilities or by Medicare. ( )

a. The hospital may: ( )

i. Be an institution licensed to operate as a hospital pursuant to law; ( )

ii. 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 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 ( )

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. ( )

b. The term will not be inclusive of the following, unless the facility otherwise meets the qualifications set forth at Paragraph 011.05.a. of this Section: ( )

i. Convalescent homes or, convalescent, rest, or nursing facilities; ( )

ii. Facilities affording primarily custodial, educational, or rehabilitory care; ( )

iii. Facilities for the aged, drug addicts, or alcoholics; or ( )

iv. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. ( )

06. Mental Disorders or Nervous Disorders. "Mental disorders" or "nervous disorders" includes neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. ( )

07. Nurse. "Nurse" may be restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms necessitates the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Idaho. ( )

08. One Period of Confinement. "One (1) period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three (3) times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days. ( )

09. Partial Disability. "Partial disability" is 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. ( )

10. Preexisting Condition. "Preexisting condition" is: ( )

a. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; ( )

b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or ( )

c. A pregnancy existing on the effective date of coverage. ( )

11. Provider. "Provider" means a person or entity that, as necessary, is licensed to provide health care or related services. ( )

12. Residual Disability. "Residual disability" is 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 necessary. A policy that provides for residual disability benefits may impose a qualification period, during which the insured needs to 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 that in the opinion of the Director adequately and fairly describes the benefit. ( )

13. Sickness or Illness. "Sickness or illness" means sickness or disease of an insured person that presents itself after the effective date of insurance and while the insurance is in force. It may exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law." ( )

14. Total Disability. "Total disability" is in accordance with the following limitations: ( )

a. The individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. ( )

b. Total disability may be defined in relation to the inability of the person to perform duties but is not to be based solely upon an individual's inability to: ( )

i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or ( )

ii. Engage in a training or rehabilitation program. ( )

c. An insurer may stipulate the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may stipulate care by a physician other than the insured or a member of the insured's immediate family. ( )

012. -- 019. (RESERVED)

020. BANNED POLICY PROVISIONS.

01. Probationary or Waiting Period. Except as provided in Subsection 011.10 pertaining to the definition of a preexisting condition or Paragraph 038.02.e. of this chapter regarding specified disease coverage, a policy or certificate will not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy or certificate. Accident policies will not contain probationary or waiting periods. ( )

02. Additional Coverage as Dividend. A policy or rider for additional coverage will not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend

policy or rider for additional coverage will not be issued for an initial term of less than six (6) months. ( )

a. The initial renewal subsequent to the issuance of a policy or rider as a dividend will clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional. ( )

03. Return of Premium or Cash Value Benefit. A disability income policy, accident only policy, limited benefit policy, specified disease policy or hospital confinement indemnity policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to this chapter is to 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. ( )

04. Exclusions. A policy or certificate will not limit or exclude coverage by type of illness, accident, treatment or medical condition, except that a policy or certificate may include one (1) or more of the following limitations or exclusions: ( )

a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child; ( )

b. Mental or emotional disorders, alcoholism and drug addiction; ( )

c. Pregnancy, except for complications of pregnancy; ( )

d. Illness, treatment or medical condition arising out of: ( )

i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; ( )

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; ( )

iii. Professional aviation for wage or profit; and ( )

iv. With respect to disability income protection policies, incarceration. ( )

e. Cosmetic surgery, except that "cosmetic surgery" will not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications or complications related to a cosmetic procedure; ( )

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 of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; ( )

h. Benefits in excess of Medicare eligible expense, if enrolled in Medicare or other governmental program (except Medicaid), or benefits provided under a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law unless the motor vehicle no-fault plan provides for coordination of benefits; 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 and the examination for the prescription, or fitting of them; ( )

k. Rest cures, custodial care, transportation, and routine physical examinations; ( )

l. Territorial limitations; ( )

m. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device. ( )

n. Missed or canceled appointments; completion of claim forms or records copying; failure to vacate a room on or before the facility's established discharge hour; educational and training services except as provided by the policy or certificate; over the counter medical supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, alcohol swabs or dressings; ( )

o. Treatment, services or supplies not prescribed by or upon the direction of a licensed provider, acting within the scope of his or her license; ( )

p. Services rendered prior to the effective date of coverage or after termination of coverage, except as provided by an extension of benefits provision, and; ( )

q. The reversal of an elective sterilization procedure, including but not limited to vasovasostomies or salpingoplasties. ( )

05. Preexisting Conditions. ( )

a. Except as provided in this subsection, a policy will not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the coverage due to a preexisting condition. ( )

b. For policies other than disability income or specified disease, an individual carrier will not modify a policy with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for specifically named preexisting diseases or conditions otherwise covered by the policy. ( )

021. -- 029. (RESERVED)

030. MINIMUM STANDARDS FOR BENEFITS.

01. Minimum Standards. The following minimum standards for benefits are prescribed for the categories of coverage noted in Sections 035 through 040 of this chapter. Such an insurance policy or certificate will not be offered, delivered, issued for delivery, or renewed in this state or to a resident of this state unless it meets the minimum standards for the specified categories or the Director finds that the policies or contracts are allowable as limited benefit health insurance, and the outline of coverage complies with the applicable model outline of coverage for each category of coverage. An insurer will deliver an outline of coverage to an applicant or enrollee with the sale. ( )

02. Renewability. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy or certificate will 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. In addition, the policy will provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, will become the insured. ( )

a. The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" will not be used without further explanatory language in accordance with the disclosure requirements of Section 101 of this chapter. ( )

b. The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy, 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. ( )

c. An individual accident and sickness or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed. ( )

d. Except as provided in Subsection 030.02 of this chapter, (the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums and, until the age of sixty-five (65) or until eligibility for Medicare and to the extent not in conflict with the federal Health Insurance Portability and Accountability Act (HIPAA), 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 where the insurer is able to show good cause for changing the policy provisions and obtains prior written approval from the Director. The insurer may make changes in premium rates by classes. ( )

03. Age and Durational Requirements. In a policy covering both husband and wife, the age of the younger spouse will be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this provision will not mandate termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse as the insured to the age or for the durational period as specified in the policy. ( )

04. Accidental Death and Dismemberment Coverage. When accidental death and dismemberment coverage is part of the policy coverage offered under the contract, the insured will have the option to include all insureds under the coverage. ( )

05. Military Service Limitations. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy will provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis. ( )

06. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits will 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. ( )

07. Convalescent or Extended Care Benefits. Policies providing convalescent or extended care benefits following hospitalization will not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital. ( )

08. Coverage of Dependents. A policy's coverage will continue for a dependent child who is incapable of self-sustaining employment due to intellectual disability or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may stipulate that the company receives due proof of the incapacity within thirty-one (31) days of the date in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. Provisions relating to coverage of dependents with intellectual disabilities or physical disabilities need meet the requirements of Sections 41-2139 and 41-2203, Idaho Code. ( )

09. Expenses of Live Donor. A policy providing coverage for the recipient in a transplant operation will 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 or certificate, after benefits for the recipient's own expenses have been paid. ( )

10. Recurrent Disabilities. A policy may contain a provision relating to recurrent disabilities, but a

provision relating to recurrent disabilities will not specify that a recurrent disability be separated by a period greater than six (6) months. ( )

11. Accidental Death and Dismemberment. Accidental death and dismemberment benefits will be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, will not require the loss to commence less than thirty (30) days after the date of accident, nor will any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force. ( )

12. Specific Dismemberment Benefits. Specific dismemberment benefits will not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits. ( )

13. Extension of Benefits. Termination of the policy will be without prejudice to a continuous loss that commenced while the policy or certificate was in force. Such 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. ( )

14. Fractures or Dislocations. A policy providing coverage for fractures or dislocations will not provide benefits only for "full or complete" fractures or dislocations. ( )

031. -- 034. (RESERVED)

035. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

a. Provides daily benefits for hospital confinement on an indemnity basis in an amount not less than forty dollars ($40) per day; and ( )

b. Provides benefits for not less than thirty-one (31) days during each period of confinement for each person insured under the policy. ( )

c. Benefits will be paid regardless of other coverage. ( )

02. Banned **Policy or Certificate Provisions**. ( )

a. Policies may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy or certificate, and the insurer demonstrates that the reserve basis for the policies is adequate. ( )

b. Policies providing hospital confinement indemnity coverage will not contain provisions excluding coverage because of confinement in a hospital operated by the federal government. ( )

c. Policies or certificates which include additional indemnity coverage on a basis other than per day of confinement will not be considered hospital confinement coverage. ( )

03. Disclosure Provisions. ( )

a. All hospital confinement indemnity policies and certificates will display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a hospital confinement indemnity (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

b. Outlines of coverage delivered in connection with "Hospital Confinement Indemnity Coverage" to persons eligible for Medicare by reason of age will contain the following language in boldface type on the first page of the outline of coverage: "THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare,

review the 'Guide to Health Insurance for People with Medicare' available from the company." ( )

c. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

036. DISABILITY INCOME PROTECTION COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply to disability income protection coverage: ( )

a. Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62); ( )

b. Contains an elimination period no greater than: ( )

i. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less; ( )

ii. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years; or ( )

iii. 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. No reduction in benefits is put into effect because of an increase in Social Security or similar benefits during a benefit period. ( )

02. Banned **Policy Provisions**. ( )

a. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be applied. ( )

b. A disability income policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate. ( )

c. Disability income benefits will not require the loss to commence less than thirty (30) days after the date of accident, nor will any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force. ( )

d. No reduction in benefits will be put into effect because of an increase in Social Security or similar benefits during a benefit period. ( )

e. No policy or certificate may use activities of daily living to define partial or total disability. ( )

03. Disclosure Provisions. All disability income protection policies will display prominently on the first page of the policy, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following: "Notice to Buyer: This is a disability income protection policy." ( )

037. ACCIDENT ONLY COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply to accident only coverage: ( )

a. Accidental death and double dismemberment amounts under the policy or certificate are at least one thousand dollars ($1,000); ( )

b. A single dismemberment amount is at least five hundred dollars ($500); and ( )

c. Benefits for disability, hospital or medical care will be as defined in the policy or certificate. ( )

02. Banned **Policy Provisions**. Accident only policies or certificates will not contain probationary or waiting periods. ( )

03. Disclosure Provisions. ( )

a. All accident-only policies and certificates will contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ( )

b. An accident-only policy or certificate providing benefits that vary according to the type of accidental cause will prominently set forth in the outline of coverage the circumstances under which benefits are payable that are less than the maximum amount payable under the policy or certificate. ( )

c. Accident-only policies or certificates that provide coverage for hospital or medical care will contain the following statement in addition to the Notice to Buyer: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

038. SPECIFIED DISEASE COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply to specified disease coverage: ( )

a. Coverage for cancer only or cancer in conjunction with other conditions or diseases needs to meet the standards of Paragraphs 01.e., 01.f., or 01.g. of this section. ( )

b. Coverage for specified diseases other than cancer meets the standards of Paragraphs 01.c., 01.d., or 01.g. of this section. ( )

c. Non-cancer Coverages with Deductible. Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars ($250) and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses: ( )

i. Hospital room and board and any other hospital furnished medical services or supplies; ( )

ii. Treatment by a legally qualified physician or surgeon; ( )

iii. Private duty services of a registered nurse (R.N.); ( )

iv. X-ray, radium and other therapy procedures used in diagnosis and treatment; ( )

v. Professional ambulance for local service to or from a local hospital; ( )

vi. Blood transfusions, including expense incurred for blood donors; ( )

vii. Drugs and medicines prescribed by a physician; ( )

viii. The rental of an iron lung or similar mechanical apparatus; ( )

ix. Braces, crutches, and wheel chairs deemed necessary by the attending physician for the treatment of the disease; ( )

x. 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; and ( )

xi. May include coverage of any other expenses necessarily incurred in the treatment of the disease. ( )

d. Non-cancer Coverages without Deductible. Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty five thousand dollars ($25,000) payable at the rate of not less than fifty dollars ($50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days. ( )

e. Cancer-only or Combination Expense Policies. Coverage for each insured person for cancer-only coverage or in combination with one (1) or more other specified diseases on an expense incurred basis for services, supplies, care, and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars ($250), and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than three (3) years for at least the following minimum provisions: ( )

i. Treatment by, or under the direction of, a legally qualified physician or surgeon; ( )

ii. X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment; ( )

iii. Hospital room and board and any other hospital furnished medical services or supplies; ( )

iv. Blood transfusions and their administration, including expense incurred for blood donors; ( )

v. Drugs and medicines prescribed by a physician; ( )

vi. Professional ambulance for local service to or from a local hospital; ( )

vii. Private duty services of a registered nurse provided in a hospital; ( )

viii. Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease; ( )

ix. 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; and ( )

x. Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment will be prescribed in writing by the insured person's attending physician, who will approve the program prior to its start. The physician certifies that hospital confinement would be otherwise necessary. Home health care includes, but is not limited to: ( )

(1) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; ( )

(2) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech, or hearing occupational therapists; ( )

(3) Physical, occupational, or speech and hearing therapy; ( )

(4) Medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital; ( )

xi. Therapy, including physical, speech, hearing, and occupational therapy; ( )

xii. Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances; ( )

xiii. Prosthetic devices including wigs and artificial breasts; ( )

xiv. Nursing home care for non-custodial services; and ( )

xv. Reconstructive surgery when deemed necessary by the attending physician. ( )

f. Per Diem Cancer Coverages. Cancer coverages on a per diem indemnity basis includes: ( )

i. A fixed-sum payment of at least one hundred dollars ($100) for each day of hospital confinement for at least three hundred sixty-five (365) days; ( )

ii. A fixed-sum payment equal to one-half (1/2) the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment; and ( )

iii. A fixed-sum payment of at least fifty dollars ($50) per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least three hundred sixty-five (365) days of treatment. ( )

g. Lump Sum Indemnity Coverage. Lump sum indemnity coverage for any specified disease will be payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. ( )

i. Dollar benefits may only be in increments of one thousand dollars ($1,000). ( )

ii. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts will be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy or certificate clearly differentiates that subtype and its benefits. ( )

h. Hospice Care. Hospice care is optional and does not cover non-terminally ill patients. If offered, it will provide: ( )

i. Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; ( )

ii. A fixed-sum payment of at least fifty dollars ($50) per day; and ( )

iii. A lifetime maximum benefit limit of at least ten thousand dollars ($10,000). ( )

i. Nursing Home Care. Benefits for skilled nursing home confinement or the receipt of home health care are optional. If offered, it will provide: ( )

i. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days, but no more restrictive than under Medicare; ( )

ii. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of home health care for at least one hundred (100) days, but no more restrictive than under Medicare; and ( )

iii. Benefit payments begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease. ( )

02. Banned **Policy or Certificate Provisions**. Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules apply to specified disease coverages in addition to all other requirements imposed by this chapter. In cases of conflict the following govern: ( )

a. Policies covering a single specified disease or combination of specified diseases are not to be sold or offered for sale other than as specified disease coverage under this Section. ( )

b. Any policy issued pursuant to this Section that conditions payment upon pathological diagnosis of a covered disease will also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. ( )

c. Notwithstanding any other provision of this chapter, specified disease policies will provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease. ( )

d. Individual accident and sickness policies containing specified disease coverage will be guaranteed renewable. ( )

e. No policy issued pursuant to this Section contains a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person. ( )

f. Except for lump sum indemnity coverage, payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. ( )

g. Benefits will be paid regardless of other coverage. ( )

h. After the effective date of the coverage (or applicable waiting period, if any) benefits begins with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage is not to be less than ninety (90) days prior to the diagnosis. ( )

i. Policies providing expense benefits will not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." ( )

j. Preexisting condition will not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person." ( )

k. Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded. ( )

03. Disclosure Provisions. ( )

a. An application or enrollment form for specified disease coverage will contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not also covered by any Title XIX program (Medicaid, or any similar name). The statement may be combined with any other statement for which the insurer may request the applicant's or enrollee's signature. ( )

b. All specified disease policies and certificates will contain on the first page in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate a prominent statement as follows: "Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage." ( )

c. Outlines of coverage delivered in connection with "Specified Disease" to persons eligible for Medicare by reason of age will contain the following language in boldface type on the first page of the outline of coverage: "THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the 'Guide to Health Insurance for People with Medicare' available from the company." ( )

d. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

039. SPECIFIED ACCIDENT COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply to specified accident coverage: ( )

a. A benefit amount not less than one thousand dollars ($1,000) for accidental death; ( )

b. A benefit amount not less than one thousand dollars ($1,000) for double dismemberment; and ( )

c. A benefit amount not less than five hundred dollars ($500) for single dismemberment. ( )

02. Banned **Policy or Certificate Provisions**. Specified accident policies will not contain probationary or waiting periods. ( )

03. Disclosure Provisions. ( )

a. Specified accident policies or certificates that provide coverage for hospital or medical care will contain the following statement in addition to the Notice to Buyer: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

b. All specified accident policies and certificates will contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ( )

040. LIMITED BENEFIT HEALTH COVERAGE.

01. Minimum Standards. ( )

a. Limited Benefit Health Coverage will not be offered, delivered, issued for delivery, or renewed in this state or to a resident of this state unless approved by the Director prior to use. ( )

b. A policy covering a single specified disease or combination of diseases will not be offered for sale

as "limited benefit" coverage. ( )

c. Section 040 does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in Title 41, Chapter 46, Idaho Code, "Long-Term Care Insurance" and Title 41, Chapter 44, Idaho Code, "Medicare Supplement Insurance Minimum Standards." ( )

02. Disclosure Provisions. ( )

a. All limited benefit health policies and certificates will display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a limited benefit health (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

b. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

041. DENTAL COVERAGE.

01. Disclosure Provisions. Dental coverage will include the following disclosures; ( )

a. All applications will contain a prominent statement in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate) carefully." ( )

b. All dental plan policies and certificates will display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides dental benefits only." ( )

042. VISION COVERAGE.

01. Disclosure Provisions. Vision coverage will include the following disclosures; ( )

a. All applications will contain a prominent statement in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully." ( )

b. All vision plan policies and certificates will display prominently on the first page of the policy or certificate in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides vision benefits only." ( )

043. -- 100. (RESERVED)

101. DISCLOSURE PROVISIONS.

01. General Rules for Disclosure Provisions. ( )

a. All applications for coverages specified in Sections 035 through 040 will contain a prominent statement in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully." ( )

b. Each policy or certificate subject to this chapter will include a renewal, continuation or nonrenewal provision. The language or specification of the provision needs to be consistent with the type of contract to be issued. The provision will be appropriately captioned, will appear on the first page of the policy or certificate, and will clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. ( )

c. 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 that reduce or eliminate benefits or coverage in the policy will necessitate signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a commensurable increase in premium during the policy term is to be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is prescribed by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium. ( )

d. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge will be set forth in the policy or certificate. ( )

e. A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import will include a definition of the terms and an explanation of the terms in its accompanying outline of coverage. ( )

f. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations will appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations." ( )

g. All policies and certificates, will have a notice prominently printed on the first page of the policy or certificate stating in substance that the policyholder or certificate holder will have the right to return the policy or certificate within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder 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 or certificate as originally issued, that fact will be prominently set forth in the outline of coverage. ( )

i. If a policy or certificate contains a conversion privilege, it will comply, in substance, with the following: ( )

i. The caption of the provision will be "Conversion Privilege" or words of similar import. ( )

ii. The provision will 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; and ( )

iii. The provision will 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. ( )

02. Outline of Coverage Requirements. Outlines of coverage prescribed under this chapter will conform to the model outlines of coverage incorporated herein in Section 002 of this chapter, and set forth at the Idaho Department of Insurance website. ( )

a. An insurer will deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans as prescribed by Section 41-4205, Idaho Code. If an application is made by electronic means, an insurer will deliver an outline of coverage on the next working day the completed application is received, and delivery may be made by the following methods regardless of the form of application: ( )

i. E-mail; ( )

ii. Website link; ( )

iii. Facsimile; ( )

iv. First class mail; or ( )

v. Any other method permitted by the Director. ( )

b. If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would necessitate revision of the outline, a substitute outline of coverage properly describing the policy or certificate will accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) boldface 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) (enrollment), and the coverage originally applied for has not been issued."** ( )

c. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage will be filed with the Director. ( )

102. -- 200. (RESERVED)

201. REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE.

01. Application Form. An application form will include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used. ( )

02. Prescribed **Notice**. Notices prescribed under this chapter will conform to the model outlines of coverage incorporated herein in Section 002 of this chapter, and set forth at the Idaho Department of Insurance website. Upon determining that a sale will involve replacement, an insurer, or its agent will furnish the applicant, prior to issuance or delivery of the policy, the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance," taking into consideration the requirement for direct response or other than direct response. A direct response insurer will deliver to the applicant upon issuance of the policy, the notice described in this section. ( )

202. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 46, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards." ( )

02. Purpose. The purpose of this chapter is 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. ( )

03. Scope and Applicability. Except as specifically provided, this chapter applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state; certain provisions of this chapter apply only to qualified long-term care insurance. Additionally, this chapter is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: ( )

a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services; ( )

b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or ( )

c. 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. ( )

002. INCORPORATION OF DOCUMENTS BY REFERENCE.

01. Forms. Documents incorporated by reference may be obtained from the Idaho Department of Insurance website. ( )

02. Documents Incorporated by Reference. This chapter incorporates by reference the following documents, appendices, and attachments of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation. The Model Regulation is available from the NAIC and from the Idaho Department of Insurance. ( )

a. Rescission Reporting Form for Long-Term Care, Appendix A. ( )

b. Personal Worksheet, Appendix B. ( )

c. Things You Should Know Before You Buy Long-Term Care Insurance, Appendix C. ( )

d. Suitability Letter, Appendix D. ( )

e. Claims Denial Reporting Form, Appendix E. ( )

f. Instructions, Appendix F. ( )

g. Replacement and Lapse Reporting Form, Appendix G. ( )

h. Outline of Coverage. ( )

i. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Attachment I. ( )

j. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance, Attachment II. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
For the purpose of this rule, the following definitions apply in addition to those found in Title 41, Chapter 46, Idaho Code. ( )

01. 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 due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. ( )

a. Except as provided in Section 025, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. ( )

b. 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. ( )

c. The director, in determining that the necessary basis for an exceptional increase exists, will determine any potential offsets to higher claims costs. ( )

02. Incidental. As used in Subsection 025.10, 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 are measured as of the date of issue. ( )

03. Qualified Actuary. Means a member in good standing of the American Academy of Actuaries. ( )

011. POLICY DEFINITIONS.
For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state may use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions are to satisfy definitions as amended by the U.S. Treasury Department and the following requirements. ( )

01. Activities of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring. ( )

02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status. ( )

03. Adult Day Care. 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. ( )

04. Bathing. 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. ( )

05. Cognitive Impairment. 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. ( )

06. Continence. 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). ( )

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. ( )

08. Eating. 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. ( )

09. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. ( )

10. Home Health Care Services. Medical and non-medical 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. ( )

11. Mental or Nervous Disorder. Limited to neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. ( )

12. Personal Care. The provision of hands-on services to assist an individual with activities of daily living. ( )

13. 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 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies 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: ( )

a. Institutional long-term care benefits only; ( )

b. Non-institutional long-term care benefits only; or ( )

c. Comprehensive long-term care benefits. ( )

14. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Defined in relation to the level of skill prescribed, the nature of the care and the setting in which care need be delivered. ( )

15. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. ( )

16. Transferring. Moving into or out of a bed, chair, or wheelchair. ( )

17. All Providers of Services. 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 is defined in relation to the services and facilities prescribed 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 also states what requirements a provider need 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. ( )

012. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms “guaranteed renewable” and “noncancellable” cannot be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 014 of this rule. ( )

a. A policy issued to an individual cannot contain renewal provisions other than “guaranteed renewable” or “noncancellable.” ( )

b. 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. ( )

c. 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. ( )

d. The term "level premium" may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy. ( )

e. In addition to the other requirements of Subsection 011.01, a qualified long-term care insurance contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. ( )

02. Limitations and Exclusions. A policy cannot be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: ( )

a. Preexisting conditions or diseases; ( )

b. Mental or nervous disorders; however, this does not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease; ( )

c. Alcoholism and drug addiction; ( )

d. Illness, treatment, or medical condition arising out of: ( )

i. War or act of war (whether declared or undeclared); ( )

ii. Participation in a felony, riot, or insurrection; ( )

iii. Service in the armed forces or units auxiliary thereto; ( )

iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or ( )

v. Aviation (this exclusion applies only to non-fare-paying passengers). ( )

e. Treatment provided in a government facility (unless prescribed by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance; ( )

f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or ( )

g. 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. ( )

h. Subsection 011.02 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: ( )

i. When the state other than the state of policy issue does not have the provider licensing, certification or registration prescribed in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or ( )

ii When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 011.02.h. "state of policy issue" means the state in which the individual policy or certificate was originally issued. ( )

iii. Subsection 011.02 is not intended to prohibit territorial limitations. ( )

03. Extension of Benefits. Termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. 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. ( )

04. Continuation or Conversion. ( )

a. Group long-term care insurance issued in this state on or after the effective date of Section 011 provides covered individuals with a basis for continuation or conversion of coverage. ( )

b. For the purposes of Section 011, "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 makes a determination as to the substantial equivalency of benefits, and in doing so, takes 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. ( )

c. For the purposes of Section 011, "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 (6) months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. ( )

d. For the purposes of Section 011, "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, takes 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. ( )

e. Written application for the converted policy is made and the first premium due, if any, is paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy is issued effective on the day following the termination of coverage under the group policy and is renewable annually. ( )

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is 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 is calculated on the basis of the insured's age at inception of coverage under the group policy replaced. ( )

g. Continuation of coverage or issuance of a converted policy is mandatory, except where: ( )

i. Termination of group coverage resulted from an individual's failure to make any prescribed payment of premium or contribution when due; or ( )

ii. 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: ( )

(1) 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 ( )

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 011.04.f. ( )

h. Notwithstanding any other provision of Section 011, 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 one hundred percent (100%) of incurred expenses. The provision is only included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable. ( )

i. 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, cannot exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. ( )

j. Notwithstanding any other provision of Section 011, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. ( )

k. For the purposes of Section 011 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. ( )

05. 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 offers 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: ( )

a. Will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and ( )

b. Cannot vary or depend on the individual's health or disability status, claim experience or use of long-term care services. ( )

06. Premium Changes. ( )

a. The premium charged to an insured cannot increase due to either: ( )

i. The increasing age of the insured at ages beyond sixty-five (65); or ( )

ii. The duration the insured has been covered under the policy. ( )

b. The purchase of additional coverage is not considered a premium rate increase, but for purposes of the calculation prescribed under Section 032, the portion of the premium attributable to the additional coverage is added to and considered part of the initial annual premium. ( )

c. A reduction in benefits is not considered a premium change, but for purpose of the calculation prescribed under Section 032, the initial annual premium is based on the reduced benefits. ( )

07. Electronic Enrollment for Group Policies. ( )

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by a producer or insurer is satisfied if: ( )

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information is provided to the enrollee; ( )

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and ( )

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. ( )

b. The insurer makes available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. ( )

013. UNINTENTIONAL LAPSE.

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance, as a protection against unintentional lapse, complies with the following: ( )

a. No individual long-term care policy or certificate is issued until the insurer has received from the applicant either a written designation of at least one (1) 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 (1) person who is to receive the notice of termination, in addition to the insured. Designation cannot constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation will provide space clearly designated for listing at least one (1) person. The designation includes each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver states: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) 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 notifies the insured of the right to change this written designation, no less often than once every two (2) years. ( )

b. 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 013.01.a. 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 clearly indicates the payment plan selected by the applicant. ( )

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate can 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 013.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is given by first class United States mail, postage prepaid; and notice cannot be given until thirty (30) days after a premium is due and unpaid. Notice is deemed to have been given as of five (5) days after the date of mailing. ( )

02. Reinstatement. In addition to the requirement in Subsection 013.01, a long-term care insurance policy or certificate includes 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 is available to the insured if requested within five (5) months after termination and allows for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy

and certificate. ( )

014. REQUISITE DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies will contain a renewability provision. ( )

a. The provision is appropriately captioned, appears on the first page of the policy, and clearly states that the coverage is guaranteed renewable or noncancellable. This provision cannot apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. ( )

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, includes a statement that the premium rates may change. ( )

02. 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 requires signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing signed by the insured, except if the increased benefits or coverage are prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy, rider or endorsement. ( )

03. 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 includes a definition of these terms and an explanation of the terms in its accompanying outline of coverage. ( )

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations appears as a separate paragraph of the policy or certificate and is labeled as "Preexisting Condition Limitations." ( )

05. 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 banned in Section 41-4605(4)(b)(i), Idaho Code, sets forth a description of the limitations or conditions, including any prescribed number of days of confinement, in a separate paragraph of the policy or certificate and labels such paragraph "Limitations or Conditions on Eligibility for Benefits." ( )

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is prescribed 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 is prominently displayed on the first page of the policy or rider and any other related documents. Subsection 014.06 cannot apply to qualified long-term care insurance contracts. ( )

07. Benefit Triggers. Activities of daily living and cognitive impairment is used to measure an insured's need for long-term care and is described in the policy or certificate in a separate paragraph and is labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers need to be explained. If these triggers differ for different benefits, explanation of the trigger accompanies each benefit description. If an attending physician or other specified person needs to certify a certain level of functional dependency to be eligible for benefits, this too needs to be specified. ( )

08. Qualified Contracts. A qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 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. ( )

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is not intended to be a qualified long-term care insurance contract. ( )

10. Requisite Disclosure of Rating Practices to Consumers. ( )

a. Subsection 014.10 applies as follows: ( )

i. Except as provided in Subsection 014.10.a.ii., Subsection 014.10 applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. ( )

ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 014.10 applies on the policy anniversary following January 1, 2002. ( )

b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers provide all of the information listed in Subsection 014.10.b. 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 provides all information listed in Subsection 014.10.b. to the applicant no later than at the time of delivery of the policy or certificate. ( )

i. A statement that the policy may be subject to rate increases in the future; ( )

ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision; ( )

iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and ( )

iv. A general explanation for applying premium rate or rate schedule adjustments that includes a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 014.10.b.ii., if the premium rate or rate schedule is changed. ( )

c. Information regarding each premium rate increase on this policy form or similar 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. ( )

d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. ( )

e. An insurer has 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 acquisition. ( )

f. 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 Subsection 014.10 or the end of a twenty-four (24) month period following the acquisition of the

block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company includes the disclosure of that rate increase in accordance with Subsection 014.10.c. ( )

g. If the acquiring insurer in Subsection 014.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from insurers referenced in Subsection 014.10.f., the acquiring insurer will make all disclosures prescribed by Subsection 014,10.c., including disclosure of the earlier rate increase referenced in Subsection 014.10.f. ( )

h. An applicant signs an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure prescribed under Subsections 014.10.b. and 014.10.c. If because of the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant signs no later than at the time of delivery of the policy or certificate. ( )

i. An insurer uses the forms in Appendices B and F to comply with the disclosure requirements of Subsection 014.10.b. and Subsection 014.10.h. ( )

j. An insurer provides notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice includes the information prescribed by Subsection 014.10.b., when the increase is implemented. ( )

015. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue contains clear and unambiguous questions designed to ascertain the health condition of the applicant. ( )

02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it will also ask the applicant to list the medication that has been prescribed. 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 be denied, then the policy or certificate cannot be rescinded for that condition. ( )

03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue: ( )

a. The following language is set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy. ( )

b. The following language, or language substantially similar to the following, is 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)." ( )

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer obtains one (1) of the following: ( )

i. A report of a physical examination; ( )

ii. An assessment of functional capacity; ( )

iii. An attending physician's statement; or ( )

iv. Copies of medical records. ( )

04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) is 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. ( )

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and annually furnishes this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A. ( )

016. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Limitations or Exclusions. A long-term care insurance policy or certificate cannot, if it provides benefits for home health care or community care services, limit or exclude benefits: ( )

a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided; ( )

b. 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; ( )

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; ( )

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of their licensure or certification; ( )

e. By excluding coverage for personal care services provided by a home health aide; ( )

f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that prescribed by the eligible service; ( )

g. By requiring that the insured or claimant have an acute condition before home health care services are covered; ( )

h. By limiting benefits to services provided by Medicare-certified agencies or providers; or ( )

i. By excluding coverage for adult day care services. ( )

02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, provides total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) 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 cannot apply to policies or certificates issued to residents of continuing care retirement communities. ( )

03. Maximum Coverage. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. ( )

017. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Inflation Protection Offer. 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 will 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 (1) of the following: ( )

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%); ( )

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined. The amount of the additional benefit is 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; or ( )

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit. ( )

d. With respect to inflation protection for a Partnership policy only: ( )

i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy will provide some level of automatic compound annual inflation protection; ( )

ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy will provide some level of automatic annual inflation protection; and ( )

iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not prescribed to) provide some level of inflation protection. ( )

02. Group Offer. Where the policy is issued to a group, the prescribed offer in Subsection 017.01 is made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603(4)(d), Idaho Code, other than to a continuing care retirement community, the offering is made to each proposed certificateholder. ( )

03. Requirements for Life Insurance Policies. The offer in Subsection 017.01 above is not prescribed of life insurance policies or riders containing accelerated long-term care benefits. ( )

04. Outline of Coverage. Insurers 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 shows 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. ( )

c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. ( )

05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these benefits 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. ( )

06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases includes an offer of a premium which the insurer expects to remain constant. The offer discloses in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant . ( )

07. Rejection of Offer. Inflation protection as provided in Subsection 017.01 is included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as prescribed in Subsection 017.07. The rejection may be either in the application or on a separate form. The rejection is considered a part of the application and states: "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 (signature line: _____)." ( )

018. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms 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 producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, 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 certificateholder has been notified of the replacement. ( )

a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations? ( )

b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? ( )

i. If so, with which company? ( )

ii. If that policy lapsed, when did it lapse? ( )

c. Are you covered by Medicaid? ( )

d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)? ( )

02. Other Policy Disclosures. Producers list any other health insurance policies they have sold to the applicant. ( )

a. List policies sold that are still in force. ( )

b. List policies sold in the past five (5) years that are no longer in force. ( )

03. 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 producer furnishes 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 (1) copy of the notice is retained by the applicant and an additional copy signed by the applicant is retained by the insurer. The prescribed notice is in a form based on the NAIC Model Regulation Attachment I. ( )

04. Direct Response Solicitations. Insurers using direct response solicitation methods deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The prescribed notice is in a form based on the NAIC Model Regulation Attachment II. ( )

05. Notice of Replacement. Where replacement is intended, the replacing insurer notifies, in writing, the existing insurer of the proposed replacement. The existing policy is identified by the insurer, name of the insured and policy number or address including zip code. Notice is 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. ( )

06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care comply with Section 018 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer complies with the replacement requirements of IDAPA 18.03.04, "Replacement of Life Insurance and Annuities." If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer complies with both the long-term care and the life insurance replacement requirements. ( )

019. REPORTING REQUIREMENTS.

01. Maintenance of Producer Records. Every insurer maintains records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the number of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales, in the format of Appendix G. ( )

02. Producers Experiencing Lapses and Replacements. Every insurer reports annually by June 30 the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by Subsection 019.01. ( )

03. Purpose of Reports. 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 producer activities regarding the sale of long-term care insurance. ( )

04. Lapsed Policies. Every insurer reports 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. ( )

05. Replacement Policies. Every insurer reports 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. ( )

06. Claims Denied. Every insurer reports 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, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition, in the format of Appendix E. ( )

07. Policies and Reports. For purposes of Section 019, "policy" means only long-term care insurance and "report" means on a statewide basis. ( )

a. Policy means only long-term care insurance; ( )

b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; ( )

c. Denied means the insurer refused to pay a claim for any reason; and ( )

d. Report means on a statewide basis. ( )

08. Filing. Reports prescribed under Section 019 are filed with the Director. ( )

020. LICENSING.
No producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Producer Licensing. ( )

021. DISCRETIONARY POWERS OF DIRECTOR.
The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate

upon a written finding that: ( )

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or ( )

02. Residential Care Community. 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 ( )

03. Other Insurance Products. 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. ( )

022. RESERVE STANDARDS.

01. Acceleration of Benefits Under Life Policies. 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 are determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life Insurance. Claim reserves will also be established in the case when the policy or rider is in claim status. ( )

02. Decrement Models. Reserves for policies and riders subject to Section 022 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 can 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. ( )

03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table is certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to Section 022, due regard is 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: ( )

a. Definition of insured events; ( )

b. Covered long-term care facilities; ( )

c. Existence of home convalescence care coverage; ( )

d. Definition of facilities; ( )

e. Existence or absence of barriers to eligibility; ( )

f. Premium waiver provision; ( )

g. Renewability; ( )

h. Ability to raise premiums; ( )

i. Marketing method; ( )

j. Underwriting procedures; ( )

k. Claims adjustment procedures; ( )

l. Waiting period; ( )

m. Maximum benefit; ( )

n. Availability of eligible facilities; ( )

o. Margins in claim costs; ( )

p. Optional nature of benefit; ( )

q. Delay in eligibility for benefit; ( )

r. Inflation protection provisions; and ( )

s. Guaranteed insurability option. ( )

04. Benefits Not Covered in Section 022. When long-term care benefits are provided other than as in Subsection 022.01 above, reserves are determined in accordance with Section 41-608, Idaho Code, "Reserve for Disability Insurance." ( )

023. LOSS RATIO.
Section 023 applies to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 024 and 025 of this chapter. ( )

01. Expected Loss Ratios. Benefits under long-term care insurance policies are 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 is given to all relevant factors, including: ( )

a. Statistical credibility of incurred claims experience and earned premiums; ( )

b. The period for which rates are computed to provide coverage; ( )

c. Experienced and projected trends; ( )

d. Concentration of experience within early policy duration; ( )

e. Expected claim fluctuation; ( )

f. Experience refunds, adjustments or dividends; ( )

g. Renewability features; ( )

h. All appropriate expense factors; ( )

i. Interest; ( )

j. Experimental nature of the coverage; ( )

k. Policy reserves; ( )

l. Mix of business by risk classification; and ( )

m. Product features such as long elimination periods, high deductibles and high maximum limits. ( )

02. Policies That Accelerate Benefits. Subsection 023.01 cannot 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: ( )

a. 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; ( )

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. ( )

c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. ( )

i. Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation. ( )

d. An actuarial memorandum is filed with the insurance department that includes: ( )

i. A description of the basis on which the long-term care rates were determined; ( )

ii. A description of the basis for the reserves; ( )

iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; ( )

iv. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any; ( )

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

vi. The estimated average annual premium per policy and the average issue age; ( )

vii. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and ( )

viii. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status. ( )

024. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it files 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. ( )

01. Initial Filing Requirements. ( )

a. Subsection 024.01 applies to any long-term care policy issued in this state on or after July 1, 2001. ( )

b. An insurer will provide the information listed in Subsection 024.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale. ( )

c. A copy of the disclosure documents prescribed in Section 014. ( )

d. An actuarial certification consisting of at least the following: ( )

i. 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; ( )

ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration; ( )

iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. ( )

e. 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; ( )

v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; ( )

vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 024.02 based on a standard age distribution; and ( )

vii. 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, ( )

viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. ( )

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration includes 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. ( )

a. In the event the director requests additional information under this provision, the period referred to in Subsection 024.01.b. of this section does not include the period of time during which the insurer is preparing the requested information. ( )

025. PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increase Notice. An insurer provides 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 includes: ( )

a. Information prescribed by Section 014. ( )

b. Certification by a qualified actuary that: ( )

i. 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; and ( )

ii. The premium rate filing is in compliance with the provisions of this Section 025. ( )

02. Actuarial Memorandum. The actuarial memorandum justifying the rate schedule change request includes: ( )

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of 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 past five (5) years preceding and the three (3) years following the valuation date are provided separately; ( )

ii. The projections include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; ( )

iii. The projections demonstrate compliance with Subsection 025.03; and ( )

iv. For exceptional increases; ( )

(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and ( )

(2) In the event the director determines as provided in Subsection 010.09.c. that offsets may exist, the insurer uses appropriate net projected experience. ( )

b. Disclosure of how reserves have been incorporated in this 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 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. ( )

e. 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 sufficient information for review of the premium rate schedule increase by the director. ( )

03. Premium Rate Schedule Increases. All premium rate schedule increases are determined in accordance with the following requirements: ( )

a. Exceptional increases provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. ( )

b. Premium rate schedule increases are 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: ( )

i. The accumulated value of the initial earned premium times fifty eight percent (58%); ( )

ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; ( )

iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and ( )

iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 025.03.b.iii. on an earned basis. ( )

c. In the event that a policy form has both exceptional and other increases, the values in Subsections 025.03.b.ii. and 025.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. ( )

d. All present and accumulated values used to determine rate increases use the maximum valuation interest rate for contract reserves. The actuary discloses as part of the actuarial memorandum the use of any appropriate averages. ( )

04. Projections Filed for Review. For each rate increase that is implemented, the insurer files for review by the director updated projections, as defined in Subsection 025.02.a., annually for the following 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 025.13, the projections prescribed by this Subsection 025.04 are provided to the policyholder in lieu of filing with the director. ( )

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 025.02.a., are filed for review by the director every five (5) years following the end of the prescribed period in Subsection 025.04. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by Subsection 025.05 are provided to the policyholder in lieu of filing with the director. ( )

06. Actual and Projected Experience. 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 the premium specified in Subsection 025.03, the director may require the insurer to implement any of the following: ( )

a. Premium rate schedule adjustments; or ( )

i. Other measures to reduce the difference between the projected and actual experience. ( )

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 025.02.d. and 025.02.e., if applicable. ( )

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer files: ( )

a. 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. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 025.08 may be applied; and ( )

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 025.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 025.03.b.i. and 025.03.b.iii. ( )

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director reviews, 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 lapse 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. ( )

d. In the event significant adverse lapse 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 option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer will; ( )

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 the maximum benefits under any new policy accepted by an insured is reduced by comparable benefits already paid under the existing policy. ( )

e. The insurer maintains 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 is 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%). ( )

09. Persistent Practice of Inadequate Rate Filings. 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 025.08 of this section, prohibit the insurer from either of the following: ( )

a. Filing and marketing comparable coverage for a period of up to five (5) years; or ( )

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. ( )

10. Exceptions. Subsection 025.01 and 025.09 does not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 010.12, if the policy complies with all of the following provisions: ( )

a. 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; ( )

b. 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: ( )

i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance; ( )

ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities; ( )

iii. IDAPA 18.03.03, Subsection 018.02, "Variable Contracts." ( )

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage. ( )

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance 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 will 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 indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates 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 prescribed premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status. ( )

13. Exceptions for Association Plans. Premium Rate Schedule Increases Subsections 025.06 and 025.08 cannot apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where: ( )

a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or ( )

b. The policyholder, and not the certificateholders, pay a material portion of the premium, which cannot 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. ( )

026. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or

other similar organization providing long-term care insurance or benefits in this state provides 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. In addition, all advertisements are retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. ( )

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement cannot be reasonably applied. ( )

027. STANDARDS FOR MARKETING AND PRODUCER TRAINING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its producers, will: ( )

a. Establish marketing procedures and producer training requirements to assure that any marketing activities, including any comparison of policies by its producers will be fair and accurate. ( )

b. Establish marketing procedures to assure excessive insurance is not sold or issued. ( )

c. 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 cannot 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." ( )

d. Provide copies of the disclosure forms prescribed in Subsection 014.10. ( )

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 032.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c. ( )

f. Inquire and 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 prescribed. ( )

g. Establish auditable procedures for verifying compliance with Subsection 027.01. ( )

h. At solicitation, provide written notice to the prospective policyholder and certificateholder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. ( )

i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 011.01.c. of this chapter. ( )

02. Banned Practices. In addition to the practices banned in Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds, the following acts and practices are banned: ( )

a. 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. ( )

b. 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. ( )

c. 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 producer or insurance company. ( )

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. ( )

03. Associations. With respect to the obligations set forth in Subsection 027.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations 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. ( )

a. The insurer files with the insurance department the following material: ( )

i. The policy and certificate; ( )

ii. A corresponding outline of coverage; and ( )

iii. All advertisements to be utilized. ( )

b. The association discloses in any long-term care insurance solicitation: ( )

i. 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 ( )

ii. A brief description of the process under which the policies and the insurer issuing the policies were selected. ( )

c. If the association and the insurer have interlocking directorates or trustee arrangements, the association discloses that fact to its members. ( )

d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates reviews and approves the insurance policies as well as the compensation arrangements made with the insurer. ( )

e. The association also will: ( )

i. 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; ( )

ii. Actively monitor the marketing efforts of the insurer and its producers; and ( )

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. ( )

iv. Subsections 027.03.e.i. through 027.03.e.iii. cannot apply to qualified long-term care insurance contracts. ( )

f. 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 prescribed in Section 027. ( )

g. The insurer cannot 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 Section 027. ( )

h. Failure to comply with the filing and certification requirements of Section 027 constitutes an unfair trade practice in violation of Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds. ( )

04. Producer Training Requirements. An individual cannot sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course and ongoing training every twenty-four (24) months thereafter. The training meets the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.06.04, "Continuing Education." ( )

a. The one-time training course prescribed by this section is no less than eight (8) hours. In addition to the one-time training course, an individual who sells, solicits, or negotiates long-term care insurance completes the ongoing training prescribed by this Subsection 027.04, which is no less than four (4) hours every twenty four (24) months. ( )

b. The training prescribed under Subsection 027.04.a. consists of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to: ( )

i. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid; ( )

ii. Available long-term care services and providers; ( )

iii. Changes or improvements in long-term care services or providers; ( )

iv. Alternatives to the purchase of private long-term care insurance; ( )

v. The effect of inflation on benefits and the importance of inflation protection; and ( )

vi. Consumer suitability standards and guidelines. ( )

c. The training prescribed by Subsection 027.04. cannot include any sales or marketing information, materials, or training, other than those prescribed by state and federal law. ( )

d. Insurers subject to this rule obtain verification that a producer receives training prescribed by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer maintains records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as prescribed by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care including Medicaid in this state. These records are maintained in accordance with the state's record retention requirements and made available to the director upon request. ( )

e. The satisfaction of these training requirements in any state satisfy the training requirements of this state. ( )

028. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 028 cannot apply to life insurance policies that accelerate benefits for long-term care. ( )

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the "issuer") will: ( )

a. 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; ( )

b. Train its producers in the use of its suitability standards; and ( )

c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. ( )

03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer; ( )

a. The producer and issuer develop procedures that take the following into consideration: ( )

i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; ( )

ii. 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 ( )

iii. 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. ( )

b. The issuer and producer, if involved, make reasonable efforts to obtain the information set out in Subsection 028.03. The efforts include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer contains, at a minimum, the information in the format contained in the NAIC Model Regulations 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 is filed with the director. ( )

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance website. ( )

c. A completed personal worksheet is 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. ( )

d. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is banned. ( )

04. Appropriateness. The issuer uses the suitability standards it has developed pursuant to Section 028 in determining whether issuing long-term care insurance coverage to an applicant is appropriate. ( )

05. Use of Standards. Producers use the suitability standards developed by the issuer in marketing long-term care insurance. ( )

06. Disclosure Form. 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" is provided. The form is in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. ( )

07. Rejection and Alternatives. 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 sends the applicant a letter similar to the NAIC Model Regulations, 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 is made part of the applicant's file. ( )

08. Reporting. The issuer reports 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. ( )

029. 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 waives 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. ( )

030. AVAILABILITY OF NEW SERVICES OR PROVIDERS.

01. Notification to Policyholder. An insurer notifies the policyholder of the availability of a new long-term care policy 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 is provided within twelve (12) months of the date the new policy is made available for sale in this state. ( )

02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not prescribed for any policy issued prior to the effective date of this Section 030 or to any policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has 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 prescribed premium to add such new services or providers. ( )

03. New Coverage. The insurer makes the new coverage available in one of the following ways: ( )

a. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age; ( )

b. 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 are based on premiums paid or reserves held for the prior policy or certificate. ( )

c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or ( )

d. By an alternative program developed by the insurer that meets the intent of Section 030 if the program is filed with and approved by the Director. ( )

04. Proprietary Policy. An insurer is not prescribed to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "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 proprietary policy are notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel. ( )

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030 are considered exchanges and not replacements. These exchanges are not subject to Section 018, and Section 028, and the reporting

requirements of Section 019.01. through 019.05. of this rule. ( )

06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the prescribed notification in Subsection 030.01 is made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification is made to each certificateholder. ( )

07. Nothing Prohibits an Insurer From Offering Coverage. Nothing in this Section 030 prohibits 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 eligibility requirements, including underwriting and payment of the prescribed premium to add such new services or providers. ( )

08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits. ( )

031. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

01. Reduction of Coverage. Every long-term care insurance policy and certificate includes a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways: ( )

a. Reducing the maximum benefit; or ( )

b. Reducing the daily, weekly or monthly benefit amount. ( )

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

02. Implementing a Reduction in Coverage. The provision includes a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. ( )

03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage is based on the age used to determine the premiums for the coverage currently in force. ( )

04. Limitations for the Reduction of Coverage. 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. ( )

05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer provides a written reminder to the policyholder or certificateholder of their right to reduce coverage and premiums in the notice prescribed by Subsection 013.01.c. of this rule. ( )

06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits. ( )

07. Compliance Requirements. The requirements of this Section 031 apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the prescribed provision via amendment or endorsement to the policy. ( )

032. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 032 does not apply to life insurance policies or riders containing accelerated long-term care benefits. ( )

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant

to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state satisfies the following: ( )

a. A policy or certificate offered with nonforfeiture benefits will 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 is the benefit described in Subsection 032.04.e. ( )

b. The offer is in writing if the nonforfeiture benefit is not described in the Outline of Coverage or other materials given to the prospective policyholder. ( )

03. Contingent Benefit. If the offer prescribed under Section 41-4607, Idaho Code, is rejected, the insurer provides the contingent benefit upon lapse described in Section 032. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. still applies. ( )

04. Rejection of Offer. After rejection of the offer prescribed under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 032, the insurer provides a contingent benefit upon lapse. ( )

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate provides either the nonforfeiture benefit or the contingent benefit upon lapse. ( )

b. A contingent benefit on lapse is 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 within Subsection 032.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

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

( )

i. A contingent benefit on lapse is also 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 one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise prescribed, policyholders are 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 is in addition to the contingent benefit provided by Subsection 032.04.b. and where both are triggered, the benefit provided is at the option of the insured. ( )

c. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b., the insurer: ( )

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; ( )

ii. Offers to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.; and ( )

iii. Notifies the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b. is the election of the offer to convert in Subsection 032.04.c.ii. unless the automatic option in Subsection 032.04.d.iii. applies. ( )

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer: ( )

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; ( )

ii. Offers 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 one hundred twenty (120) day period referenced in Subsection 032.04.b.i.; and ( )

iii. Notifies the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. is the election of the offer to convert in Subsection 032.04.d.ii. 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 032.04.b. but not Subsection 032.04.b.i. are described in Subsection 032.04.e. ( )

i. For purposes of this Subsection 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); ( )

ii. For purposes of Subsection 032.04.e., the nonforfeiture benefit is 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 are determined as specified in Subsection 032.04.e.iii.; ( )

iii. The standard nonforfeiture credit will be equal to one hundred percent (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 cannot 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 032.04.f.; ( )

iv. The nonforfeiture benefit begins not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse is effective during the first three (3) years as well as thereafter. ( )

v. Notwithstanding Subsection 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit begins on the earlier of: ( )

(1) The end of the tenth year following the policy or certificate issue date; or ( )

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. ( )

vi. 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 is no difference in the minimum nonforfeiture benefits as prescribed under Section 032 for group and individual policies. ( )

h. For certificates issued on or after the effective date of this Section 032, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section 032 cannot apply. ( )

i. The last sentence Subsection 032.03 and Subsection 032.04.b. and Subsection 032.04.d. applies to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one (1) year after adoption. ( )

i. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of Section 023 or Section 025, whichever is applicable, treating the policy as a whole. ( )

j. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 032.04.b. or 032.04.b.i., a replacing insurer that purchased or assumed a block or blocks of long-term care insurance policies from another insurer calculates 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 is offered that meets the following requirements: ( )

i. The nonforfeiture provision is appropriately captioned; ( )

ii. The nonforfeiture provision provides a benefit available in the event of a default on the payment of any premiums and states 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 filed for review with the Director for the same contract form; and ( )

iii. The nonforfeiture provision provides at least one (1) of the following: ( )

(1) Reduced paid-up insurance; ( )

(2) Extended term insurance; ( )

(3) Shortened benefit period; or ( )

(4) Other similar offerings approved by the Director. ( )

033. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions of Benefits Payment. A long-term care insurance policy conditions 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 is not 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. ( )

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 033.02 as long as they are defined in the policy. Activities of daily living includes at least the following as defined in Section 010 and in the policy. ( )

a. Bathing; ( )

b. Continence; ( )

c. Dressing; ( )

d. Eating; ( )

e. Toileting; and ( )

f. Transferring. ( )

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions cannot restrict, and are not in lieu of, the requirements contained in Subsections 033.01 and 033.02. ( )

04. Determinations of Deficiency. For purposes of Section 033 the determination of a deficiency cannot be more restrictive than: ( )

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or ( )

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others. ( )

05. Assessments. Assessments of activities of daily living and cognitive impairment are performed by licensed or certified professionals, such as physicians, nurses or social workers. ( )

06. Appeals. Long-term care insurance policies include a clear description of the process for appealing and resolving benefit determinations. ( )

07. Effective Date. The requirements set forth in Section 033 are effective within twelve (12) months of the effective date of the rule and apply as follows: ( )

a. Except as provided in Subsection 033.07.b. the provisions of Section 033 apply to a long-term care policy issued in this state on or after the effective date of the rule. ( )

b. For certificates issued on or after the effective date of Section 033, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which was in force at the time this rule became

effective, the provisions of Section 033 do not apply. ( )

034. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 034 the following definitions apply: ( )

a. Qualified long-term care services means services that meet the requirements of Section 7702B(a)(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 prescribed by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. ( )

b. 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. ( )

c. The term chronically ill individual cannot include an individual meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. ( )

d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. ( )

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). ( )

02. The Chronically Ill. A qualified long-term care insurance contract pays 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. ( )

03. Payments and Conditions. A qualified long-term care insurance contract conditions 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. ( )

04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment prescribed pursuant to Subsection 034.03 are performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. ( )

05. Certifications by Carrier. Certification prescribed pursuant to Subsection 034.03 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 cannot be rescinded and additional certifications cannot be performed until after the expiration of the ninety (90) day period. ( )

06. Appeals. Qualified long-term care contracts include a clear description of the process for appealing

and resolving benefit determinations. ( )

035. STANDARD FORMAT OUTLINE OF COVERAGE.
Section 035 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. ( )

01. Format. The outline of coverage is a freestanding document, using no smaller than ten (10) point type. 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. ( )

02. Content. The outline of coverage contains no material of an advertising nature. ( )

03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage is published on the Department of Insurance website. ( )

036. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

01. Approved Format. 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, is provided to all prospective applicants of a long-term care insurance policy or certificate. ( )

a. In the case of producer solicitations, a producer will deliver the shopper's guide prior to the presentation of an application or enrollment form. ( )

b. In the case of direct response solicitations, the shopper's guide will be presented in conjunction with any application or enrollment form. ( )

02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not obligated to furnish the above-referenced guide, but furnish the policy summary prescribed under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. ( )

037. PENALTIES.
In addition to any other penalties provided by the laws of this state any insurer and any producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards," is subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater. ( )

038. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 47, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.12, "The Small Employer Health Insurance and Availability Act." ( )

02. Scope. The Act and this chapter are intended to promote broader spreading of risk in the small employer marketplace and to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this chapter. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
As used in this chapter: ( )

01. Associate Member. Any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following: ( )

a. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or ( )

b. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan). ( )

02. Expense. The cost incurred for a covered service or supply. A physician or other licensed practitioner orders or prescribes the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: ( )

a. For a service or supply that is not medically necessary; or ( )

b. That is in excess of reasonable and customary charge for a service or supply. ( )

03. Geographic Area. A sector of land, as designated by the health carrier, which employers sitused within receive a specified rating factor. Geographic areas are limited to no more than six (6) designated areas, with no area being smaller than a county. ( )

04. Medically Necessary Service or Supply. One that is ordered by a physician and that the small employer carrier or a qualified party determines is: ( )

a. Provided for the diagnosis or direct treatment of an injury or sickness; ( )

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; ( )

c. Is not considered experimental or investigative; ( )

d. Provided in accord with generally accepted medical practice; ( )

e. The most appropriate supply or level of service which can be provided on a cost-effective basis. The fact that the insured person's physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. ( )

05. New Entrant. An eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan. ( )

06. Pre-Existing Condition. ( )

a. A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; ( )

b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or ( )

c. A pregnancy existing on the effective date of coverage. ( )

d. Genetic information will not be considered as a condition described in this definition in the absence of a diagnosis of the condition related to such information. ( )

07. Risk Characteristic. The health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of a small employer group or of any member of a small employer group. Such characteristics can include family composition, group size, industry. ( )

08. Risk Load. The percentage above the applicable base premium rate that is charged by a small employer carrier to the rates of the small employer group, to reflect the risk characteristics of the small employer group. ( )

011. ASSESSMENTS.
Prior to March 1st of each year the Board determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer Reinsurance Program in the previous calendar year. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known. ( )

012. -- 014. (RESERVED)

015. APPLICABILITY.

01. Applicability. This chapter applies to any health benefit plan provided on a group basis, that: ( )

a. Meets one (1) or more of the conditions set forth in Section 41-4704, Idaho Code; and ( )

b. Offers coverage to two (2) or more eligible employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state. ( )

02. Group Policy or Trust Arrangement. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group unless such health benefit plan(s) are subject to Title 41, Chapter 52, Idaho Code. ( )

03. Group Policy or Trust Arrangement. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group. ( )

04. Subsequent Employment of More Than Fifty Eligible Employees. If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this chapter continue to apply to the health benefit plan in the case that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer, within sixty (60) days of becoming aware that the employer has more than fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan,

notifies the employer that the protections provided under the Act and this chapter cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. ( )

05. Employer Subsequently Becomes a Small Employer. If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act do not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer does not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. ( )

06. Time Period for Notification of Options to Employer. A carrier providing coverage to an employer described in Subsection 015.05, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notifies the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. ( )

07. Employees in More Than One State. If a small employer has employees in more than one (1) state, the provisions of the Act and this chapter apply to a health benefit plan issued to the small employer if: ( )

a. The majority of eligible employees of such small employer are employed in this state; or ( )

b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. ( )

08. Laws of This State or Another State. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.07, the provisions of the paragraph is applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. ( )

09. Health Benefit Plan Subject to The Act and This Chapter. If a health benefit plan is subject to the Act and this chapter, the provisions of the Act and this chapter applies to all individuals covered under the health benefit plan, whether they reside in this state or in another state. ( )

10. When Is a Small Employer Carrier Not Subject to the Act and This Chapter. A carrier that is not operating as a small employer carrier in this state does not become subject to the provisions of the Act and this chapter solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. ( )

016. -- 020. (RESERVED)

021. ESTABLISHMENT OF CLASSES OF BUSINESS.

01. Supporting Documentation for Establishment of Classes of Business. A small employer carrier that establishes more than one class of business pursuant to the provisions of Section 41-4705, Idaho Code, maintains on file for inspection by the Director the following information with respect to each class of business so established: ( )

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business; ( )

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 41-4705, Idaho Code; and ( )

c. A statement disclosing that, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans. ( )

02. Group Size Is Not a Class of Business. A carrier will not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business. ( )

022. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. A small employer carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless: ( )

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; ( )

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, ( )

c. The transaction meets the other requirements of this Section. ( )

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier makes a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this chapter. The Director will not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable. ( )

03. Filing Requirements. The filing for Subsection 028.02 will: ( )

a. Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; ( )

b. Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to Subsection 028.08 or will incorporate them into an existing class of business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into an existing class of business, the filing will describe the class of business of the assuming carrier into which the health benefit plans will be incorporated; ( )

c. Describe whether the health benefit plans being assumed are currently available for purchase by small employers; ( )

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; ( )

e. Describe the potential effect of the assumption, if any on the premiums for the health benefit plans to be assumed; ( )

f. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and ( )

g. Include any other information prescribed by the Director. ( )

04. Informational Filings in Other States. A small employer carrier prescribed to make a filing under

Subsection 028.02 will also make an informational filing with the Insurance Supervisory Official of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the small employer health benefit plans in that state. ( )

05. Other Considerations in the Transfer and Assumption of the Entire Insurance Obligation. A small employer carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions: ( )

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering small employers in this state. ( )

b. If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in Section 41-4706(1)(a), Idaho Code, the assuming carrier makes a filing with the Director pursuant to Section 41-4706(3), Idaho Code, seeking suspension of the application of Section 41-4706(1)(a), Idaho Code. ( )

c. An assuming carrier seeking suspension of the application of Section 41-4706(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering small employers in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. ( )

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-4706(1)(a), Idaho Code, with respect to an assumed class of business, is for no more than fifteen (15) months and, with respect to each individual small employer, lasts only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business). ( )

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, a small employer carrier will not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business within Idaho which includes such health benefit plan. ( )

07. Requirements for Ceding Less Than an Entire Class of Business. A small employer carrier may cede less than an entire class of business to an assuming carrier if: ( )

a. One (1) or more small employers in the class have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction includes each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or ( )

b. After a written request from the transferring carrier, the Director determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business. ( )

08. Separate Class of Business. Except as provided in Subsection 028.09, a small employer carrier that assumes one (1) or more health benefit plans from another carrier will maintain such health benefit plans as a separate class of business. ( )

09. Provisions for Exceeding the Maximum Number of Classes of Business. A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 41-4705(2), Idaho Code, (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions: ( )

a. Upon assumption of the health benefit plans, such health benefit plans are maintained as a separate

class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans are transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier selects the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans. ( )

b. The transfers authorized in Paragraph 028.09.a. occurs with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business. ( )

c. A small employer carrier making a transfer pursuant to Paragraph 028.09.a. may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred. ( )

d. The premium rate for an assumed small employer health benefit plan is not modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to Paragraph 028.09.a. Upon transfer, the assuming small employer carrier calculates a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan is no higher than the risk load applicable to such health benefit plan prior to the assumption. ( )

e. During the fifteen-month (15) period provided in this Subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection is considered a violation of Section 41-4706(2), Idaho Code. ( )

10. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier will not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. ( )

11. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of a small employer carrier. The application is made within sixty (60) days from assumption of the class of business and clearly states the justification for a longer transition period. ( )

12. Additional Information. Nothing in this Section or in the Act is intended to: ( )

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; ( )

b. Authorize a carrier not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or ( )

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. ( )

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.
The following provisions are applicable for all small employer health benefit plans. ( )

01. Separate Rate Manual for Each Class of Business. A small employer carrier develops a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such

discretion. ( )

02. Requirements for Adjustments to Rating Method. A small employer carrier will not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this Section. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this chapter. ( )

03. Information for Review of Modification of Rating Method. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information: ( )

a. The reasons the change in rating method is being requested; ( )

b. A complete description of each of the proposed modifications to the rating method; ( )

c. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan); ( )

d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and ( )

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code. ( )

04. Change in Rating Method. For the purpose of this Section, a change in rating method means: ( )

a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer will not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); ( )

b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; ( )

c. A change in the method of allocating expenses among health benefit plans in a class of business; or ( )

d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). ( )

e. For the purpose of this Subsection, a change in a rating factor means the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier considers the cumulative effect of all such changes in applying the ten percent (10%) test. ( )

05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied. The rate manual developed pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. ( )

06. Uniform Application of Case Characteristics. A small employer carrier uses the same case characteristics as defined in Section 41-4706(1)(h), Idaho Code, in establishing premium rates for each health benefit plan in a class of business and applies them in the same manner in establishing premium rates for each such health

benefit plan. Case characteristics are applied without regard to the risk characteristics of a small employer. ( )

07. Base Premium Rates and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 clearly illustrates the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual illustrates the difference. ( )

08. Reasonable and Objective Rate Differences. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and will not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier applies case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. ( )

09. Two-Step Process. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two-step process. In the first step, a base premium rate is developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. ( )

10. Exception to Application Fee, Underwriter Fee, or Other Fees. Except as provided in Subsection 036.11, a premium charged to a small employer for a health benefit plan will not include a separate application fee, underwriting fee, or any other separate fee or charge. ( )

11. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and are included in determining compliance with the Act and this chapter. ( )

12. Uniform Allocation of Administration Expenses. The rate manual developed pursuant to Subsection 036.01 describes the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed. ( )

13. Rate Manual to be Maintained for a Period of Six Years. Each rate manual developed pursuant to Subsection 036.01 is maintained by the carrier for a period of six (6) years. Updates and changes to the manual are maintained with the manual. ( )

14. Guidelines Issued by Director. The rate manual and rating practices of a small employer carrier will comply with any guidelines issued by the Director. ( )

15. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and are applied as follows: ( )

a. A small employer carrier revises its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. ( )

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate is the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(i), Idaho Code. ( )

c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan is considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Section 41-4706(1)(c)(i), Idaho Code. ( )

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier makes a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing is made within thirty (30) days of the beginning of the rating period. ( )

e. A small employer carrier keeps on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. ( )

16. Change in Premium Rate. Except as provided in Subsection 036.17, a change in premium rate for a small employer produces a revised premium rate that is no more than the following: ( )

a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by; ( )

b. One (1) plus the sum of: ( )

i. The risk load applicable to the small employer during the previous rating period; and ( )

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). ( )

17. Plans No Longer Enrolling New Business. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer will produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Paragraphs 036.17.a. and 036.17.b. ( )

a. One (1) plus the lesser of: ( )

i. The change in the base rate; or ( )

ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers. ( )

b. One (1) plus the sum of: ( )

i. The risk load applicable to the small employer during the previous rating period; and ( )

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). ( )

18. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.16 and 036.17, a change in premium rate for a small employer will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code. ( )

19. Waiver Request for a Taft-Hartley Trust. A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. ( )

20. Provisions for Which Trust Is Seeking Waiver. A request made under Subsection 036.19 identifies the provisions for which the trust is seeking the waiver and describes, with respect to each provision, the extent to which application of such provision would: ( )

a. Adversely affect the participants and beneficiaries of the trust; and ( )

b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant

to which the trust was or is established or maintained. ( )

21. Waiver Not for an Individual or Associate Member. A waiver granted under this provision will not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. ( )

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer of Coverage. A small employer carrier that offers coverage to a small employer will offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier provides the same health benefit plan to each such employee and dependent. ( )

02. Choice of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one (1) or more health benefit plans, provided that each eligible employee may choose any of the offered plans. The choice among benefit plans will not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. ( )

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. ( )

04. Employer Census and Supporting Documentation. A small employer carrier will require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of dependents and eligible employees as defined in Sections 41-4703(11) and 41-4703(13), Idaho Code. The small employer carrier may require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. ( )

05. Waiver for Documentation of Coverage. A small employer carrier will secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver is signed by the eligible employee (on behalf of such employee or the dependent of such employee) and certifies that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form requires that the reason for declining coverage be stated on the form, and includes a statement informing the eligible employee of the special enrollment rights provided within the Section 41-4703(17)(d) and (e), Idaho Code, and includes a written warning of the penalties imposed on late enrollees. Waivers are maintained by the small employer carrier for a period of six (6) years. ( )

06. Refusal to Provide Information. A small employer carrier will not issue coverage to a small employer that refuses to provide the list prescribed under Subsection 046.04 or a waiver prescribed under Subsection 046.05, except if the excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan. ( )

07. Induced Declinations. A small employer carrier will not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to a health status related factor of the individual. ( )

08. Agent Notification to Small Employer Carrier. An agent will notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. ( )

09. New Entrants. New entrants to a small employer group are offered an opportunity to enroll in the

health benefit plan currently held by such group based upon the provisions of Section 41-4708, Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of their opportunity to enroll. The period of continuous coverage will not include any waiting period for the effective date of the new coverage applied by the employer to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant is offered the same choice of health benefit plans as the other members of the group. ( )

10. Waiting Period. A small employer carrier will not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3), Idaho Code). ( )

11. Risk Characteristics. New entrants to a group are accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3), Idaho Code. ( )

12. Risk Load. A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load is the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group. ( )

13. Rescission Employer Misstatements. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option against the coverage of an entire small employer (including employees and dependents) and is limited to circumstances under which the application misstatements have been made by the small employer. When rescission action is taken, per Section 41-4707(1)(b), Idaho Code, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. ( )

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

Restrictions on offering small group health insurance. A carrier that has been banned from writing coverage for small employers in this state pursuant to Section 41-4707(2), Idaho Code, will not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Director to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. ( )

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-4703(17), 41-4703(23), and 41-4708(3)(c), Idaho Code, a small employer carrier interprets the Act no less favorably to an insured individual than the following: ( )

a. A health benefit plan, certificate, or other health benefit arrangement is considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement. ( )

02. Source of Previous or Existing Coverage. A small employer carrier will ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. ( )

03. Certification of Creditable Coverage. Small employer carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. ( )

a. A small employer carrier satisfies the certification requirements if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by another person. ( )

b. To the extent coverage under a health benefit plan consists of group coverage, the plan satisfies the certification requirements if the small employer carrier offering the coverage is prescribed to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier. ( )

c. A small employer carrier is not obligated to provide information regarding health benefit plan coverage provided to an individual by another person. ( )

i. If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy provides sufficient information to the small employer carrier, or to another person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases. ( )

ii. The provision of the information pursuant to Subparagraph 060.03.c.i. to the new carrier satisfies the entity's obligation to provide an automatic certificate. ( )

iii. The carrier providing the information about creditable coverage cooperates with other carriers in responding to any request for additional information. ( )

iv. If the individual's coverage under a group health plan ceases, the carrier that issued the group policy provides an automatic certificate of coverage. ( )

d. A small employer carrier provides a certification of creditable coverage, without charge, to participants or dependents who are or were covered under the group health benefit plan. ( )

e. A small employer carrier provides a certificate at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date the individual's coverage ceased under the plan. ( )

i. Each small employer carrier establishes a procedure for individuals to request and receive certificates. Upon a receipt of the request, the small employer carrier provides the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate. ( )

f. The certificate provided includes: ( )

i. The date the certificate was issued; ( )

ii. The name of the group health plan that provided the coverage described in the certificate; ( )

iii. The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan; ( )

iv. The name, address, and telephone number of the plan administrator prescribed to provide the certificate; ( )

v. The telephone number to call for further information regarding the certificate; ( )

vi. Either a statement that the individual has at least twelve (12) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or the date any waiting period or

affiliation period, if applicable, began and the date creditable coverage began; and ( )

vii. The date creditable coverage ended, unless the certificate indicates that the creditable coverage is continuing as of the date of the certificate. ( )

g. Small employer carriers may provide a certificate by first-class mail, at the participant's last known address. ( )

h. The model for the certification of coverage may be found on the Department of Insurance Internet website. ( )

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.
Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier will not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions, including but not limited to pregnancy, or services otherwise covered by the plan. ( )

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier to Actively Market. A small employer carrier actively markets each of its health benefit plans to small employers in this state. ( )

02. Marketing Mandated Plans. In marketing the mandated health benefit plans to small employers, a small employer carrier uses at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state is also authorized to market the mandated health benefit plans. ( )

03. Offer in Writing. A small employer carrier offers all small group health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer may be provided directly to the small employer or delivered through a producer. The offer is in writing and includes at least the following information: ( )

a. A general description of the benefits and base rates contained in all actively marketed, including but not limited to the mandated, health benefit plans; and ( )

b. Information describing how the small employer may enroll in the plans. ( )

04. Timeliness of Price Quote. A small employer carrier provides a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier notifies a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. ( )

05. Toll-Free Telephone Service. A small employer carrier establishes and maintains a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service provides information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to apply for coverage. ( )

06. Restrictions as to Contribution to Association. The small group carrier will not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small

employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708, Idaho Code. ( )

07. No Requirement to Qualify for Other Insurance Product. A small employer carrier will not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. ( )

08. Plans Subject to Requirements. Carriers offering group health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the Act and this chapter. ( )

09. Annual Filing Requirement. A small employer carrier files annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director: ( )

a. The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); ( )

b. The number of small employers that were covered under the each mandated health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). ( )

c. The number of small employer health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; ( )

d. The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; ( )

e. The number of small employer health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and ( )

f. The number of health benefit plans that were issued to residents that were uninsured for at least sixty-three (63) days prior to issue. ( )

10. Total Number of Residents. All carriers file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss or stop loss plans. ( )

11. Filing Date. The information described in Subsections 075.09 and 075.10 is filed no later than March 15, each year. ( )

12. Specific Data. For purposes of this section, health benefit plan information includes policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. ( )

076. -- 080. (RESERVED)

081. LIMITATIONS AND EXCLUSIONS.

01. Allowances. A health benefit plan will not limit or exclude coverage by type of illness, accident, treatment, or medical condition, except as follows: ( )

a. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. ( )

b. Custodial, convalescent or intermediate level care or rest cures. ( )

c. Services that are experimental or investigational. ( )

d. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. ( )

e. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. ( )

f. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services. ( )

g. Cosmetic surgery and services, except for treatment or surgery for congenital anomaly and mastectomy reconstruction as described in the Women's Health and Cancer Rights Act. ( )

h. Artificial insemination, infertility treatment, and the treatment of sexual dysfunction not related to organic disease. ( )

i. Services for reversal of elective, surgically or pharmaceutically induced infertility. ( )

j. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. ( )

k. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. ( )

l. One thousand dollars ($1,000) per year limit, subject to the policy deductible, coinsurance, or copayment, on manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities. ( )

m. Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. ( )

n. Hearing or speech tests without illness being suspect. ( )

o. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device. ( )

p. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. ( )

q. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. ( )

r. Care incurred before the effective date of the person's coverage. ( )

s. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. ( )

t. Injury or sickness caused by war or armed international conflict. ( )

u. Sex change operations and treatment in connection with transsexualism. ( )

v. Marriage and family and child counseling except as specifically allowed in the policy. ( )

w. Acupuncture. ( )

x. Private duty nursing except as specifically allowed in the policy. ( )

y. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. ( )

z. Services incurred after the date of termination of a covered person's coverage except as allowed by any extension of benefits provision of the policy. ( )

aa. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. ( )

bb. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. ( )

cc. Charges for screening examinations except as otherwise provided in the policy. ( )

dd. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. ( )

ee. Pre-existing conditions, except as provided specifically in the policy. ( )

i. A health benefit plan will not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition. ( )

ii. A health benefit plan waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan. ( )

iii. A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period will not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan. ( )

082. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 52, and 55, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.13, "The Individual Health Insurance Availability Act." ( )

02. Scope. The Act and this chapter are intended to promote broader spreading of risk in the individual marketplace. The Act and chapter are intended to regulate all health benefit plans sold to eligible individuals. Carriers that provide health benefit plans to eligible individuals are intended to be subject to all of the provisions of the Act and this chapter. ( )

002. INCORPORATION BY REFERENCE.
The Outline of Coverage for Individual Major Medical Expense Coverage is incorporated by reference into this chapter from the April 1999 version of the National Association of Insurance Commissioners Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
As used in this chapter: ( )

01. Geographic Area. Geographic areas are limited to six (6) designated areas, with no area being smaller than a county. ( )

02. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of an individual. Such characteristics can include family composition. ( )

03. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by an individual carrier to the rates of the eligible individual, to reflect the risk characteristics of the eligible individual. ( )

04. Idaho Resident. Idaho resident means a person who is able to provide satisfactory proof of having resided in Idaho, as their place of domicile for a continuous six (6) month period, for purposes of being an eligible individual pursuant to Section 41-5203(10), Idaho Code. The six (6) month residency requirements would be waived for eligible individuals based on the Health Insurance Portability and Accountability Act of 1996. ( )

011. POLICY DEFINITIONS.
An insurance policy subject to this chapter will not apply definitions more restrictive than the following: ( )

01. Accident. "Accident," "accidental injury," and "accidental" is to employ "result" language and does 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. ( )

a. "Injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. ( )

b. It may exclude injuries for which benefits are provided: ( )

i. Under workers' compensation, employers' liability, or similar law; or ( )

ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or ( )

iii. For injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. ( )

02. Convalescent Nursing Home. Includes "extended care facility," or "skilled nursing facility." Is to be defined in relation to its status, facility and available services. ( )

a. Such home or facility is to: ( )

i. Be operated pursuant to law; ( )

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; ( )

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; ( )

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and ( )

v. Maintain a daily medical record of each patient. ( )

b. Such home or facility definition may exclude: ( )

i. A home, facility or part of a home or facility used primarily for rest; ( )

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or ( )

iii. A home or facility primarily used for the care and treatment of mental or nervous disorders, or for custodial or educational care. ( )

03. Home Health Care Agency. An agency approved under Medicare, or that is licensed to provide home health care under applicable state law. ( )

04. Hospice. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: ( )

a. For terminally ill patients whose life expectancy is less than six (6) months; ( )

b. Provided on an inpatient or outpatient basis; and ( )

c. Directed by a physician. ( )

05. Hospital. Is defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation of Rehabilitation Facilities or by Medicare. ( )

a. The term “hospital” may: ( )

i. Be an institution licensed to operate as a hospital pursuant to law; ( )

ii. 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 licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and ( )

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. ( )

b. The term “hospital” may exclude, unless the facility otherwise meets the requirements: ( )

i. Convalescent homes or, convalescent, rest, or nursing facilities; ( )

ii. Facilities affording primarily the care and treatment of mental or nervous disorders, or for custodial educational, or rehabilitative care; ( )

iii. Facilities for the aged, drug addicts, or alcoholics; or ( )

iv. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. ( )

06. Mental or Nervous Disorders. Neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. ( )

07. Pre-existing Condition. ( )

a. A condition or disease that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; ( )

b. A condition or disease for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or ( )

c. A pregnancy existing on the effective date of coverage. ( )

08. Sickness or Illness. A sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. It may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law. ( )

09. Total Disability. An individual not engaged in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. ( )

a. It may be defined in relation to the inability of the person to perform duties but will not be based solely upon an individual's inability to: ( )

i. Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or ( )

ii. Engage in a training or rehabilitation program. ( )

b. An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a provider other than the insured or a member of the insured's immediate family. ( )

012. ASSESSMENTS.
The Board, prior to March 1st of each year, determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer and Individual Health Reinsurance Program. The March 1, 2001 assessment anticipated by Section 41-4711, Idaho Code, will consist of the amounts needed to cover the claims cost of the individual policies issued on or before June 30, 2000. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid, on behalf of the Idaho Individual High Risk Reinsurance Pool, will be credited to each carrier’s account when the amounts needed to fund losses and pay program expenses are known. ( )

013. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. An individual carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual in this state unless: ( )

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; ( )

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, ( )

c. The transaction meets the other requirements of this Section. ( )

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more individual health benefit plans from another carrier makes a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this chapter. The Director will not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable. ( )

03. Filing Requirements. The filing for Subsection 028.02 will: ( )

a. Describe the health benefit plan (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; ( )

b. Describe whether the assuming carrier will maintain the assumed health benefit plans (pursuant to Subsection 028.08) or will incorporate them into existing business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into existing business, the filing will describe the business of the assuming carrier into which the health benefit plans will be incorporated; ( )

c. Describe whether the health benefit plans being assumed are currently available for purchase by eligible individuals; ( )

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; ( )

e. Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed; ( )

f. Describe any other potential material effects of the assumption on the coverage provided to the eligible individuals covered by the health benefit plans to be assumed; and ( )

g. Include any other information prescribed by the Director. ( )

04. Informational Filings in Other States. An individual carrier prescribed to make a filing under Subsection 028.02 will also make an informational filing with the Insurance Supervisory Official of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the individual health benefit plans in that state. ( )

05. Considerations in the Transfer and Assumption of the Entire Insurance Obligation. An individual carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an eligible individual in this state unless it complies with the following provisions: ( )

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the

proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering eligible individuals in this state. ( )

b. If the assumption of a health benefit plan would result in the assuming individual carrier being out of compliance with the limitations related to premium rates contained in Section 41-5206(1)(a), Idaho Code, the assuming carrier makes a filing with the Director pursuant to Section 41-5206(2), Idaho Code, seeking suspension of the application of Section 41-5206(1)(a), Idaho Code. ( )

c. An assuming carrier seeking suspension of the application of Section 41-5206(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering eligible individuals in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. ( )

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-5206(1)(a), Idaho Code, with respect to assumed one (1) or more health benefit plans, is for no more than fifteen (15) months and, with respect to each individual, lasts only until the anniversary date of such individual's coverage (except that the period with respect to an individual may be extended beyond such individual first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the health benefit plan). ( )

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, an individual carrier will not cede or assume the entire insurance obligation or risk for an individual health benefit plan unless the transaction includes the ceding to the assuming carrier of all business within Idaho which includes such health benefit plan. ( )

07. Requirements for Ceding Less Than Entire Business. An Individual carrier may cede less than an entire health benefit plan to an assuming carrier if: ( )

a. One (1) or more eligible individuals in the health benefit plan have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction includes each health benefit plan with the exception of those health benefit plans for which an eligible individual has rejected the proposed cession; or ( )

b. After a written request from the transferring carrier, the Director determines that the transfer of less than all health benefit plans is in the best interests of the eligible individuals insured. ( )

08. Separate Health Benefit Plans. Except as provided in Subsection 028.09, an individual carrier that assumes one (1) or more health benefit plans from another carrier may maintain such health benefit plans as a separate health benefit plan. ( )

09. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier will not apply eligibility requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to an eligible individual covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. ( )

10. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of an individual carrier. The application is made within sixty (60) days from assumption of the health benefit plan and clearly states the justification for a longer transition period. ( )

11. Additional Information. Nothing in this Section or in the Act is intended to: ( )

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; ( )

b. Authorize a carrier not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or ( )

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in

Section 41-511, Idaho Code, or provided by law. ( )

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.
The following provisions are applicable for all individual health benefit plans. ( )

01. Rate Manual. An individual carrier develops a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by an individual carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such discretion. ( )

02. Requirements for Adjustments to Rating Method. An individual carrier will not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this Section. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this chapter. ( )

03. Information for Review of Modification of Rating Method. A carrier may modify the rating method for its individual business only with prior approval of the Director. A carrier requesting to change the rating method for its individual business makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information: ( )

a. The reasons the change in rating method is being requested; ( )

b. A complete description of each of the proposed modifications to the rating method; ( )

c. A description of how the change in rating method would affect the premium rates currently charged to eligible individuals in the health benefit plan, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); ( )

d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and ( )

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for eligible individuals that would be in violation of Section 41-5206, Idaho Code. ( )

04. Change in Rating Method. For the purpose of this Section a change in rating method means: ( )

a. A change in the number of case characteristics used by an individual carrier to determine premium rates for health benefit plans in its individual business (an individual carrier will not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); ( )

b. A change in the method of allocating expenses among health benefit plans; or ( )

c. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any individual that exceeds ten percent (10%). ( )

d. For the purpose of this Subsection, a change in a rating factor means the cumulative change with respect to such factor considered over a twelve (12) month period. If an individual carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier considers the cumulative effect of all such changes in applying the ten percent (10%) test. ( )

05. Rate Manual to Specify Case Characteristics and Rate Factors. The rate manual developed

pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. ( )

06. Prior Approval of Case Characteristics. An individual carrier will not use case characteristics other than those specified in Section 41-5206(1)(f), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval makes a filing with the Director for a change in rating method under Subsection 036.02. ( )

07. Uniform Application of Case Characteristics. An individual carrier uses the same case characteristics in establishing premium rates for each health benefit plan and applies them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics are applied without regard to the risk characteristics of an eligible individual. ( )

08. Base Premium Rates and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 clearly illustrates the relationship among the base premium rates charged for each health benefit plan. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual illustrates the difference. ( )

09. Reasonable and Objective Rate Differences. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and cannot be based in any way on the actual or expected health status or claims experience of the eligible individual or groups that choose or are expected to choose a particular health benefit plan. An individual carrier applies case characteristics and rate factors within its health benefit plans in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the individuals that choose or are expected to choose a particular health benefit plan. ( )

10. Two-Step Process. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two (2) step process. In the first step, a base premium rate is developed for the eligible individual without regard to any risk characteristics. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-5206, Idaho Code, to reflect the risk characteristics of the individual. ( )

11. Exception to Application Fee, Underwriter Fee or Other Fees. Except as provided in Subsection 036.12, a premium charged to an individual for a health benefit plan will not include a separate application fee, underwriting fee, or any other separate fee or charge. ( )

12. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to all health benefit plans. All such fees are premium and are included in determining compliance with the Act and this chapter. ( )

13. Uniform Allocation of Administration Expenses. The rate manual developed pursuant to Subsection 036.01 describes the method of allocating administrative expenses to the health benefit plans for which the manual was developed. ( )

14. Rate Manual to be Maintained for a Period of Six Years. Each rate manual developed pursuant to Subsection 036.01 is maintained by the carrier for a period of six (6) years. Updates and changes to the manual are maintained with the manual. ( )

15. Guidelines Issued by Director. The rate manual and rating practices of an individual carrier comply with any guidelines issued by the Director. ( )

16. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-5206(1)(b), Idaho Code, and are applied as follows: ( )

a. An individual carrier revises its rate manual each rating period to reflect changes in base premium

rates and changes in new business premium rates. ( )

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate is the change in the base premium rate for the purposes of Sections 41-5206(1)(b)(i) and 41-5206(1)(d)(i), Idaho Code. ( )

c. If for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan is considered a health benefit plan into which the individual carrier is no longer enrolling new eligible individuals for the purposes of Section 41-5206(1)(b)(i), Idaho Code. ( )

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan by more than twenty percent (20%), the carrier makes a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing is made within thirty (30) days of the beginning of the rating period. ( )

e. An individual carrier keeps on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. ( )

17. Change in Premium Rate. Except as provided in Subsection 036.18, a change in premium rate for an eligible individual produces a revised premium rate that is no more than the following: ( )

a. The base premium rate for the eligible individual, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by: ( )

b. One (1) plus the sum of: ( )

i. The risk load applicable to the eligible individual during the previous rating period; and ( )

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). ( )

18. Plans No Longer Enrolling New Business. In the case of a health benefit plan into which an Individual carrier is no longer enrolling new Individuals, a change in premium rate for an Individual will produce a revised premium rate that is no more than the base premium rate for the Individual (given its present composition and as shown in the rate manual in effect for the Individual at the beginning of the previous rating period), multiplied by Paragraphs 036.18.a. and 036.18.b.; ( )

a. One (1) plus the lesser of: ( )

i. The change in the base rate; or ( )

ii. The percentage change in the new business premium for the most similar health benefit plan into which the Individual carrier is enrolling new Individuals. ( )

b. One (1) plus the sum of: ( )

i. The risk load applicable to the Individual during the previous rating period; and ( )

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). ( )

19. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code. ( )

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE INDIVIDUALS.

01. Offer of Coverage. An individual carrier that offers coverage to an individual will offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. ( )

02. Risk Characteristics. Individuals are accepted for coverage by the individual carrier without any restrictions or limitations on coverage related to the risk characteristics of the Individual or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-5208(3), Idaho Code. ( )

03. Risk Load. An individual carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-5206, Idaho Code. The risk load is the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan. ( )

04. Rescission. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option. When rescission action is taken, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. ( )

05. Coverage Rescinded for Fraud or Misrepresentation. Any individual whose coverage is subsequently rescinded for fraud or misrepresentation will not be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and cannot be deemed to have "qualifying previous coverage" under Title 41, Chapter 22, 47, 52, or 55, Idaho Code; provided such limitations are not in conflict with the Health Insurance Portability and Accountability Act of 1996. ( )

06. Certification of Creditable Coverage. ( )

a. Individual carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. ( )

b. The certification of creditable coverage is provided: ( )

i. At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision; ( )

ii. In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and ( )

iii. Such certification is automatically provided by the individual carrier or at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraphs 046.06.b.i. and 046.06.b.ii., whichever is later. ( )

c. The certificate of creditable coverage contains: ( )

i. Written certification of the period of creditable coverage of the individual under the health benefit plan; and ( )

ii. The waiting period, if any, and if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan. ( )

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

01. Restrictions on Offering Individual Health Insurance. An individual carrier that has been banned from writing coverage for individuals in this state pursuant to Section 41-5207(2), Idaho Code, will not resume offering health benefit plans to individuals in this state until the carrier has made a petition to the Director to be reinstated as an individual carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. ( )

02. Geographic Service Areas. In the case of an individual carrier doing business in an established geographic service area of the state, if the individual carrier elects to non-renew a health benefit plan under Section 41-5207(3), Idaho Code, the individual carrier is banned from offering health benefit plans to individuals in that service area for a period of five (5) years. ( )

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-5203(20), and 41-5208(3), Idaho Code, an individual carrier interprets the Act no less favorably to an insured individual than the following: ( )

a. An individual carrier ascertains the source of previous or existing coverage of each eligible individual and each dependent of an eligible individual at the time such individual or dependent initially enrolls into the health benefit plan provided by the individual carrier. ( )

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.
Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier will not modify or restrict any health benefit plan with respect to any eligible individual or dependent of an eligible individual, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such individual or dependent for specific diseases, medical conditions or services otherwise covered by the plan.
( )

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Individual Carrier to Actively Market. An individual carrier actively markets each of its health benefit plans to individuals in this state. ( )

02. Offer. An individual carrier offers all health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer may be provided directly to the individual or delivered through a producer. The offer is in writing and includes at least the following information: ( )

a. A general description of the benefits contained in the all actively marketed health benefit plans; and ( )

b. Information describing how the individual may enroll in the plans. ( )

04. Timeliness of Price Quote. An individual carrier provides a price quote to an individual (directly or through an authorized producer) within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. An individual carrier notifies an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote. ( )

05. Restrictions as to Application Process. An individual carrier will not apply more stringent or

detailed requirements related to the application process for the mandated health benefit plans than are applied for other health benefit plans offered by the carrier. ( )

06. Denial of Coverage. If an individual carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial is in writing and maintained in the individual carrier's office. This written denial states with specificity the risk characteristic(s) of the individual that made it ineligible for the health benefit plan it requested (for example, health status). The denial is accompanied by a written explanation of the availability of any mandated health benefit plans from the individual carrier. The explanation includes at least the following: ( )

a. A general description of the benefits contained in each such plan; ( )

b. A price quote for each such plan; and ( )

c. Information describing how the individual may enroll in such plans. ( )

d. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the individual or delivered through an authorized producer. ( )

07. Premium Rate Charged. The price quote prescribed under Paragraph 075.06.b. is for the lowest premium rate charged under the rating system for a health benefit plan for which the individual is eligible. ( )

08. Toll-Free Telephone Service. An individual carrier establishes and maintains a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service provides information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to apply for coverage. ( )

09. No Requirement to Qualify for Other Insurance Product. An individual carrier will not require, as a condition to the offer of sale of a health benefit plan to an individual, that the individual purchase or qualify for any other insurance product or service. ( )

10. Plans Subject to Requirements. Carriers offering individual health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the Act and this chapter. ( )

11. Annual Filing Requirement. An individual carrier files annually the following information with the Director related to health benefit plans issued by the individual carrier to individuals in this state on forms prescribed by the Director: ( )

a. The number of individuals that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); ( )

b. The number of individuals that were covered under each mandated health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). ( )

c. The number of individual health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; ( )

d. The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; ( )

e. The number of individual health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and ( )

f. The number of health benefit plans that were issued to residents that were uninsured for at least the sixty-three (63) days prior to issue. ( )

12. Total Number of Residents. All carriers file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss and stop loss plans. ( )

13. Filing Date. The information described in Subsections 075.11 and 075.12 is filed no later than March 15, each year. ( )

14. Specific Data. For purposes of this section, health benefit plan information includes policies or certificates of insurance for specific disease, hospital confinement indemnity, reinsurance by way of excess loss, and stop loss coverages. ( )

076. -- 080. (RESERVED)

081. BANNED POLICY PROVISIONS.

01. Probationary or Waiting Period. Except as provided in Subsection 081.02 for a pre-existing condition, a policy cannot contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. ( )

02. Pre-existing Conditions. A policy will not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the coverage due to a pre-existing condition. ( )

a. A policy waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. ( )

b. A carrier will not modify a policy with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for specifically named pre-existing conditions otherwise covered by the policy. ( )

03. Exclusions. A policy cannot limit or exclude coverage by type of illness, accident, treatment or medical condition, except that a policy may include one or more of the following limitations or exclusions: ( )

a. Pre-existing conditions, except for congenital anomalies of a covered dependent child; ( )

b. Mental or nervous disorders, alcoholism and drug addiction; ( )

c. Pregnancy, except for complications of pregnancy; ( )

d. Illness, treatment or medical condition arising out of: ( )

i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; ( )

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; and ( )

iii. Professional aviation for wage or profit; ( )

e. Cosmetic surgery, except that “cosmetic surgery” cannot include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications related to a cosmetic procedure; ( )

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 of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; ( )

h. Benefits in excess of Medicare eligible expense, if enrolled in Medicare or other governmental program (except Medicaid), or benefits provided under a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law unless the motor vehicle no-fault plan provides for coordination of benefits; 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 and the examination for the prescription or fitting of them; ( )

k. Rest cures, custodial care, transportation, and routine physical examinations; ( )

l. Territorial limitations; ( )

m. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device; ( )

n. Missed or cancelled appointments; completion of claim forms or records copying; failure to vacate a room on or before the facility's established discharge hour; educational and training services except as provided by the policy; over the counter medical supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, alcohol swabs or dressings; ( )

o. Treatment, services or supplies not prescribed by or upon the direction of a licensed provider, acting within the scope of his or her license; ( )

p. Services rendered prior to the effective date of coverage or after termination of coverage, except as provided by an extension of benefits provision; and ( )

q. The reversal of an elective sterilization procedure, including but not limited to vasovasostomy or salpingoplasty. ( )

082. GENERAL MINIMUM STANDARDS.
An insurance policy subject to this chapter cannot be offered, delivered or issued for delivery, continued or renewed in this state unless it meets the following minimum standards. ( )

01. Outline of Coverage. An insurer will deliver an outline of coverage to an applicant or enrollee with the sale, which complies with the model outline of coverage established by the National Association of Insurance Commissioners ("NAIC"), incorporated herein in Section 002. ( )

a. If an outline of coverage was delivered at the time of application or enrollment and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy will accompany the policy 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) (enrollment), and the coverage originally applied for has not been issued." ( )

b. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage is to be submitted to the Director for prior written approval. ( )

02. Coverage of Dependents. A policy will consider as an eligible dependent a child who is chiefly dependent on the insured for support and maintenance and who is incapable of self-sustaining employment due to intellectual disability or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children. The policy may require that within thirty-one (31) days of such date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. ( )

03. Limitation on Termination of Coverage of Dependent. A policy cannot provide for termination of coverage of a covered dependent solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy will provide that in the event of the insured's death, the spouse or dependent of the insured, if covered under the policy, will become the insured. ( )

04. Continuous Loss Extension. Termination of the policy will be without prejudice to a continuous loss that commenced while the policy was in force. Such 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. ( )

05. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits will 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. ( )

06. Expenses of Live Donor. A policy providing coverage for the recipient in a transplant operation also provides reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid. ( )

07. Fractures or Dislocations. A policy providing coverage for fractures or dislocations will not provide benefits only for "full or complete" fractures or dislocations. ( )

08. Coinsurance. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage will not exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan will not exceed sixty percent (60%) of covered charges. ( )

083. -- 100. (RESERVED)

101. DISCLOSURE PROVISIONS.

01. Requisite Provisions. Each policy will include a renewal, continuation or nonrenewal provision. The language or specification of the provision will be consistent with the type of contract to be issued. The provision will be appropriately captioned, will appear on the first page of the policy, and will clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. ( )

02. Added Riders or Endorsements. Riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term will be agreed to in writing and signed by the policyholder, except if the increased benefits or coverage is prescribed by law. ( )

03. Separate Additional Premium. Where a separate additional premium is charged for benefits

provided in connection with riders or endorsements, the premium charge is set forth in the policy. ( )

04. Requisite Definition of Terms. A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import will include a definition of the terms and an explanation of the terms in its accompanying outline of coverage. ( )

05. Pre-existing Conditions Limitations. If a policy contains any limitations with respect to pre-existing conditions, the limitations will appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations." ( )

06. Requisite Notice. All policies will have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy within ten (10) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder holder is not satisfied for any reason. ( )

102. -- 999. (RESERVED)

18.04.14 – COORDINATION OF BENEFITS

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 21, 22 and 34, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.14, "Coordination of Benefits." ( )

02. Scope. This chapter applies to all plans, as defined. It allows plans to include a coordination of benefits (COB) provision unless banned by federal law; establish a uniform order of benefit determination under which plans pay claims; provide authority for the orderly transfer of necessary information and funds between plans; reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to these rules, do not pay their benefits first; reduce claims payment delays; and require that COB provisions be consistent with this rule; and provide greater efficiency in the processing of claims when a person is covered under more than one (1) plan. ( )

002. INCORPORATION BY REFERENCE.
This rule incorporates by reference the full text of the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Contract Provisions (Appendix A) and the NAIC Consumer Explanatory Booklet (Appendix B), published as part of the NAIC 2013 Coordination of Benefits model regulation and available on the Idaho Department of Insurance website. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise: ( )

01. Allowable Expense. Any health care expense including coinsurance or copayments, and without reduction for any applicable deductible that is covered in full or in part by any of the plans covering the person. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that will not be subject to the deductible as described in Section 223 (c) (2) (C) of the Internal Revenue Code of 1986. An expense that a provider by law or in accordance with contractual agreement is banned from charging a covered person is not an allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. ( )

a. The following are examples of expenses or services that are not an allowable expense: ( )

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans provides coverage for private hospital rooms) is not an allowable expense. ( )

ii. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense. ( )

iii. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense. ( )

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment is the allowable expense used by the secondary plan to determine its benefits. ( )

b. The definition of the "allowable expense" may exclude certain types of coverage or benefits such

as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expenses in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract the definition of "Allowable Expense" includes similar expenses to which COB applies. ( )

c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid. ( )

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: ( )

i. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services: or ( )

ii. Because the covered person has a lower benefit because the covered person did not use a preferred provider. ( )

02. Birthday. Refers only to month and day in a calendar year and does not include the year in which the individual is born. ( )

03. Claim. A request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: ( )

a. Services (including supplies); ( )

b. Payment for all or a portion of the expenses incurred; ( )

c. A combination of Paragraphs 010.03.a. and 010.03.b. of this chapter; or ( )

d. An indemnification. ( )

04. Closed Panel Plan. A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. ( )

05. Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA". Coverage provided under a right of continuation pursuant to federal law. ( )

06. Coordination of Benefits (COB). A provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. ( )

07. Custodial Parent. The parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. ( )

08. Group-Type Contract. A contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. ( )

09. High-Deductible Health Plan. Has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. ( )

10. Hospital Indemnity Benefits. The 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. ( )

11. Plan. A form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its contract states the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan," or some other term such as "program," the contractual definition may be no broader than this definition. The definition of "plan" in the incorporated Appendix A is an example. ( )

a. Plan includes: ( )

i. Group and nongroup insurance contracts and subscriber contracts; ( )

ii. Uninsured group or group-type coverage arrangements; ( )

iii. Group and nongroup coverage through closed panel plans; ( )

iv. Group-type contracts; ( )

v. The medical care components of long-term care contracts, such as skilled nursing care; ( )

vi. Medicare or other governmental benefits, except as provided in Subparagraph 010.11.b.ix. of this chapter. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. ( )

vii. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts. No plan is prescribed to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it will do so in compliance with the provisions of this chapter. ( )

viii. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental or vision care. ( )

b. Plan does not include: ( )

i. Hospital indemnity coverage or other fixed indemnity coverage; ( )

ii. School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; ( )

iii. Specified disease or specified accident coverage; ( )

iv. Accident only coverage; ( )

v. Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; ( )

vi. Limited benefit health coverage as defined in IDAPA 18.04.08, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule." ( )

vii. Medicare supplement policies; ( )

viii. A state plan under Medicaid; or ( )

ix. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. ( )

12. Policyholder. The primary insured named in a non-group insurance policy. ( )

13. Primary Plan. A plan whose benefits for a person's health care coverage needs to be determined without taking the existence of any other plan into consideration. A plan is a primary plan if; ( )

a. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; or ( )

b. All plans that cover the person use the order of benefit determination prescribed by this rule, and under those rules the plan determines its benefits first. ( )

14. Secondary Plan. A plan that is not a primary plan. ( )

011. -- 020. (RESERVED)

021. USE OF MODEL COB CONTRACT PROVISION.

01. Coordination of Benefits. The incorporated by reference Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections 021.02 through 021.04 and the provisions of Section 022. ( )

02. Coordination of Benefits Attachment. The incorporated by reference Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which two (2) or more plans will pay for or provide benefits. ( )

03. Application of Requirements. The COB provision contained in the incorporated by reference Appendix A and the plain language explanation in the incorporated by reference Appendix B do not have to use the specific words and format as shown. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted. ( )

04. Limits on COB Provisions. A COB provision will not be used that permits a plan to reduce benefits on the basis that: ( )

a. Another plan exists and the covered person did not enroll in that plan; ( )

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 that could have been elected. ( )

05. "Always Excess" or "Always Secondary." No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accordance with this rule. ( )

06. Closed Panel Provider. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans; the secondary plan will use the provisions of Section 023 of this chapter to determine the amount it should pay for the benefit. ( )

07. Plan Requirements. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Subsection 010.11 of this rule. ( )

022. RULES FOR COORDINATION OF BENEFITS.

01. Order of Benefit Payments. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: ( )

a. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. ( )

b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan pays or provides benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. ( )

c. When multiple contracts providing coordinated coverage are treated as a single plan under this rule, Section 022 of this chapter applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one (1) carrier pays or provides benefits under the plan, the carrier designated as primary within the plan is responsible for the plan's compliance with this rule. ( )

d. If a person is covered by more than one (1) secondary plan, the order of benefit determination requirements of this rule decide the order in which secondary plan benefits are determined in relation to each other. Each secondary plan takes into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the requirements of this rule, has its benefits determined before those of that secondary plan. ( )

02. Consistent Order of Benefit Provisions. Except as provided in Paragraph 022.02.a. of this chapter, a plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of Subsection 022.02 of this chapter, state that the complying plan is primary. ( )

a. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. ( )

b. A plan may take into consideration the benefits paid or provided by another plan only when, under the requirements of this rule, it is secondary to that other plan. ( )

03. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies. ( )

a. The plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is: ( )

i. Secondary to the plan covering the person as a dependent; and ( )

ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree, is the secondary plan and the other plan covering the person as a dependent is the primary plan. ( )

b. Unless there is a court decree stating otherwise, plans covering a dependent child determine the order of benefits as follows: ( )

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married: ( )

(1) The plan of the parent whose birthday falls earlier in the calendar year is primary plan; or ( )

(2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. ( )

ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: ( )

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provisions; ( )

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph 022.03.b.i. of this chapter determine the order of benefits; ( )

(3) If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph 022.03.b.i. of this chapter determine the order of benefits; or ( )

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows: ( )

(a) The plan covering the custodial parent; ( )

(b) The plan covering the custodial parent's spouse; ( )

(c) The plan covering the noncustodial parent; and then ( )

(d) The plan covering the noncustodial parent's spouse. ( )

(5) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable under Subparagraph 022.03.b.i. or 022.03.b.ii. of this chapter as if those individuals were parents of the child. ( )

(6) For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the provisions of Paragraph 022.02.e. apply. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule in Subparagraph 022.02.b.i. to the dependent child's parent(s) and the dependent's spouse. ( )

c. The plan that covers a person as an active employee; that is, an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. 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. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Paragraph 022.03.a. of this chapter. ( )

d. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. 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. This provision does not apply if the rule in Paragraph 022.03.a. of this chapter can determine the order of benefits. ( )

e. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for a shorter period of time is the secondary plan. ( )

i. To determine the length of time a person has been covered under a plan, two (2) successive plans are treated as one (1) if the covered person was eligible under the second plan within twenty-four (24) hours after the coverage under the first plan ended. ( )

ii. The start of a new plan does not include: ( )

(1) A change in the amount or scope of a plan's benefits; ( )

(2) A change in the entity that pays, provides or administers the plan's benefits; or ( )

(3) A change from one type of plan to another such as from a single employer plan to a multiple employer plan. ( )

iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group is used as the date from which to determine the length of time the person's coverage under the present plan has been in force. ( )

f. If none of the preceding rules determines the order of benefits, the allowable expenses are shared equally between the plans. ( )

023. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.
In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan calculates the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred percent (100%) of the total allowable expense for that claim. In addition, the secondary plan credits to its plan deductible any amounts it would have credited to its deductible in the absence of other benefit care coverage. ( )

024. NOTICE TO COVERED PERSONS.
A plan, in its explanation of benefits provided to covered persons, includes the following language: "If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan." ( )

025. MISCELLANEOUS PROVISIONS.

01. Benefits in the Form of Services. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of 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 requires 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. ( )

02. Complying Plan Versus Noncomplying Plan. A plan with order of benefit determination rules that comply with this rule (complying plan) may coordinate its benefits with a plan that is "excess" or "always

secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this rule (noncomplying plan) on the following basis: ( )

a. If the complying plan is the primary plan, it pays or provides its benefits first; ( )

b. If the complying plan is the secondary plan, it pays or provides its benefits first, but the amount of the benefits payable is determined as if the complying plan were the secondary plan. In such a situation, the payment is 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 assumes that the benefits of the noncomplying plan are identical to its own and pays its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as the actual benefits of the noncomplying plan, it adjusts payments accordingly. ( )

i. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person 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 advances to the covered person or on behalf of the covered person an amount equal to the difference. ( )

ii. In no event does the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or services. In consideration of the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan is to be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation. ( )

03. COB Versus Subrogation. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. ( )

04. Timely Payment of Benefits. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan is obligated to pay more than it would have paid had it been primary. ( )

026. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 21, 42, and 52, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.15, "Rules Governing Short-Term Health Insurance Coverage." ( )

02. Purpose and Scope. Implement Title 41, Chapters 21, 42, and 52, Idaho Code, regarding short-term, limited-duration insurance by defining rules for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and disclosure provisions. ( )

03. Applicability. This rule applies to all enhanced short-term plans and nonrenewable short-term coverage that provide medical expense coverage. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the applicable definitions in Chapters 21, 42, and 52, Idaho Code, the following definitions apply: ( )

01. Benchmark Medical Plan. The health benefit plan identified by the U.S. Department of Health and Human Services to be applicable in establishing minimum benefit coverages by Qualified Health Plans within Idaho, excluding any supplements for pediatric dental or vision. ( )

02. Exchange. Has the meaning set forth in Section 41-6103, Idaho Code. ( )

03. Nonrenewable Short-term Coverage. Short-term, limited-duration insurance that is not renewable, has a duration of six (6) months or less in total, and is not an Enhanced Short-term Plan under Section 41-5203(11), Idaho Code, and this rule. ( )

04. Preexisting Condition. ( )

a. A condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; ( )

b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or ( )

c. A pregnancy existing on the effective date of coverage. ( )

05. Qualified Health Plan or QHP. A health plan certified as such by the Exchange. ( )

06. Reissuance or Replace. The practice of issuing a short-term, limited-duration insurance policy covering at least one individual having short-term, limited-duration insurance coverage within sixty-three (63) days of the policy's effective date. ( )

07. Short-term, Limited-duration Insurance. Health insurance coverage pursuant to a contract that has a specified expiration date less than twelve (12) months after the original effective date of the contract and, including renewals or extensions, has a total duration of no longer than thirty-six (36) months. ( )

011. GENERAL RULES FOR ENHANCED SHORT-TERM PLANS.

01. Application of Requirements. Any short-term, limited-duration insurance that, including renewals, reissuance or extensions, has a total duration of longer than six (6) months is subject to the requirements applicable to enhanced short-term plans. ( )

02. Guaranteed Issue. Enhanced short-term plans are only to be offered on a guaranteed issue basis. ( )

03. Portability. Enhanced short-term plan coverage is qualifying previous coverage under Title 41,

Chapter 52, Idaho Code. Preexisting condition exclusions are to be waived for the period of time an individual was previously covered by an enhanced short-term plan or other qualifying previous coverage. ( )

04. Requirement to Offer Exchange Plans. To offer an enhanced short-term plan, a carrier is to offer individual QHPs through the Exchange in the same service area. ( )

012. GENERAL RULES FOR NONRENEWABLE SHORT-TERM COVERAGE.
Nonrenewable short-term coverage is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101. ( )

013. -- 019. (RESERVED)

020. ENROLLMENT.

01. Enhanced Short-term Plans. There are two exclusive options for enhanced short-term plan enrollment. ( )

a. Year-round Enrollment. If a carrier allows year-round enrollment in enhanced short-term plans, the following provisions apply: ( )

i. A preexisting condition exclusion period, as defined at Subsection 010.04, may be applied, subject to Section 41-5208, Idaho Code. ( )

ii. The policy is to be offered on a plan year basis, not a calendar year basis. ( )

b. Annual Open Enrollment Period. If a carrier restricts enrollment in enhanced short-term plans to an annual open enrollment period, the following apply: ( )

i. No preexisting condition exclusion period may be applied. ( )

ii. The beginning and ending dates of the open enrollment period are identical to those for enrollment in QHPs, unless the Director allows an extension of the open enrollment period for enhanced short-term plans after determining it is in the public interest. ( )

iii. Special enrollment periods are to be allowed to the same extent as QHP enrollment. ( )

02. Nonrenewable Short-term Coverage. Nonrenewable short-term coverage is to be offered on a year-round basis. ( )

021. RENEWAL AND REISSUANCE.

01. Enhanced Short-term Plans Renewals. ( )

a. A policy is to be renewable at the option of the enrollee, consistent with Section 41-5207, Idaho Code. ( )

b. No new application or questions concerning the health or medical condition of the covered individuals may be requested to effectuate the renewal. ( )

c. A policy is not to be renewable beyond thirty-six (36) consecutive months. ( )

d. Upon exhaustion of a policy's renewability due to duration or age, the policyholder is eligible for enrollment into fully renewable coverage, including all of the current carrier's QHPs, when an enhanced short-term policy has been in effect for at least eleven (11) months. Timely notification of eligibility is to be provided to the policyholder plus the notification of any offer of reissuance. ( )

02. Enhanced Short-term Plans Reissuances. Upon exhausting renewability due to duration or age,

the following provisions apply to reissuance: ( )

a. No new application or questions concerning the health or medical condition of the covered individuals may be requested for reissuance. ( )

b. The reissuance premium rate is a change in premium rate subject to IDAPA 18.04.13.036.17. ( )

03. Nonrenewable Coverage. Carriers are not to renew nonrenewable short-term coverage and are not to reissue or replace nonrenewable short-term coverage issued by the same or another carrier. ( )

022. RATING REQUIREMENTS.

01. Enhanced Short-term Plans. In addition to the requirements applicable to individual health benefit plans, the following rating requirements apply: ( )

a. Premium rates do not vary by gender. ( )

b. Geographic rating areas are identical to those used for Exchange-offered QHPs. ( )

c. Medical underwriting criteria may be used to ascertain the risk characteristics of an applicant, if the criteria are limited to those in the Universal Health Statement Addendum and available claims data. ( )

d. Enhanced short-term plans comprise a single risk pool with the carrier's other actively marketed individual health benefit plans subject to Title 41, Chapter 52, Idaho Code. ( )

e. The rating period is on a calendar year basis, whereby the rates filed apply to all enrollees uniformly during a given calendar year and premium rate changes occur at the start of a new calendar year. ( )

02. Nonrenewable Short-term Coverage. The following rating requirements apply: ( )

a. The rates cannot utilize case characteristics other than age, individual tobacco use, and geography but may vary by the duration of coverage requested. ( )

b. Case characteristics are applied uniformly, without regard to the risk characteristics of an eligible individual. ( )

c. The premium rate is not affected by an applicant's risk characteristics or health status. ( )

d. The premium rate remains the same for the duration of the policy. ( )

023. -- 029. (RESERVED)

030. MINIMUM STANDARDS FOR BENEFITS.

01. Minimum Covered Benefits. ( )

a. Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides; ( )

b. Miscellaneous hospital services; ( )

c. Surgical services; ( )

d. Anesthesia services; ( )

e. In-hospital medical services; and ( )

f. Out-of-hospital care, 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, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician. ( )

02. Minimum Additional Benefits. A separate premium corresponding to additional benefits offered through a rider is to be filed and actuarially justified. A policy is to provide not fewer than three (3) of the following additional benefits: ( )

a. In-hospital private duty registered nurse services; ( )

b. Convalescent nursing home care; ( )

c. Diagnosis and treatment by a radiologist or physiotherapist; ( )

d. Rental of special medical equipment, as defined by the insurer in the policy; ( )

e. Artificial limbs or eyes, casts, splints, trusses or braces; ( )

f. Treatment for functional nervous disorders, and mental and emotional disorders; or ( )

g. Out-of-hospital prescription drugs and medications. ( )

03. Enhanced Short-term Plans Covered Benefits. The following covered benefits and limitations are to be provided consistent with the Benchmark Medical Plan, including: ( )

a. Ambulatory (outpatient) patient services; ( )

b. Emergency services; ( )

c. Hospitalization; ( )

d. Maternity and newborn care; ( )

e. Mental health and substance use disorder services, including behavioral health treatment; ( )

f. Prescription drugs; ( )

g. Rehabilitative and habilitative services and devices; ( )

h. Laboratory services; and ( )

i. Preventive and wellness services and chronic disease management. ( )

04. Prescription Drug Formulary. If a prescription drug coverage formulary is applied, the applicable formulary drug list is to: ( )

a. Include at least one drug in every United States Pharmacopeia (USP) category and class; ( )

b. Cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all covered disease states, and does not discourage enrollment by any group of enrollees; and ( )

c. Provide appropriate access to drugs included in broadly accepted treatment guidelines and indicative of then-current general best practices. ( )

05. Cost Sharing. ( )

a. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage is not to exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan is not to exceed sixty percent (60%) of covered charges. ( )

b. The maximum out-of-pocket is to be stated in the policy and in aggregate is not to exceed four percent (4%) of the aggregate annual limit under the policy for each covered person. All deductibles, copayments, coinsurance and any other cost-sharing are applicable to the maximum out-of-pocket. Within the aggregate maximum, the policy may include separate out-of-pocket limits applicable to particular services. ( )

c. The annual limit is no less than one million dollars ($1,000,000) for each covered person. ( )

d. Enhanced short-term plans are to provide coverage for and not impose any cost sharing requirements for preventive and wellness services consistent with QHP requirements. ( )

06. Applicability of Mental Health Parity. Enhanced short-term plans are to meet the requirements of Section 2726 of the Public Health Service Act (Mental Health Parity and Addiction Equity Act) in the same manner and extent as QHPs. ( )

07. Benefit Requirements. The minimum benefits imposed by Subsections 030.01, 030.02, and 030.03 may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. Except as disallowed by Subsections 030.03, 030.05, and 030.06, a policy may also have special or internal limitations for nursing facilities, transplants, experimental treatments, services covered under Subsection 030.02, and other special or internal limitations authorized by the Director. Except as authorized by this Subsection through the application of special or internal limitations, a policy will cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to prior written approval by the Director or another rate agreed to between the insurer and provider, for covered services up to the annual limit. ( )

031. -- 039. (RESERVED)

040. DISCLOSURE PROVISIONS.
Polices subject to this chapter will include in the application for coverage, any application materials, and the insurance contract, the following language in at least 14-point type:

"This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage." ( )

041. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Section 41-211, Idaho Code, to aid in the effectuation of Title 41, Chapter 27 and Section 41-1314, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.05.01, "Rules for Title Insurance Regulation." ( )

02. Purpose. This rule applies to all title insurers and title insurance agents and: ( )

a. Defines and clarifies the meaning of "a complete set of tract indexes or abstract records" as used in Section 41-2702, Idaho Code. ( )

b. Provides procedural rules as to the way title insurers, title insurance agents and escrow officers are to perform certain actions, charge rates for various services, and provide insurability on certain matters. ( )

c. Clarifies consumer protection on title insurance products. ( )

d. Preserves the financial stability of title insurers and title insurance agents. ( )

e. Defines certain fair trade practice standards for title insurance, the violation of which will constitute rebates and/or illegal inducements by Sections 41-2708(3) and 41-1314, Idaho Code. This rule does not limit the Director's authority to determine that other title insurance trade practices constitute violations of Title 41, Chapter 27 and 41-1314, Idaho Code. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
All terms defined in Title 41, Chapters 1, 13, and 27, Idaho Code, which are used in this rule will have the same meaning as used in those chapters. ( )

01. Applicant. A party to a real estate transaction who may be the buyer, seller and/or a proposed or named insured on a title commitment, policy, guaranty or other title insurance product. ( )

02. Financial Interest. Any interest that entitles the holder in any manner to two and one-half percent (2.5%) or more of the profits or net worth of the title entity in which the interest is held. ( )

03. Policy. Any contract or form of title insurance which prior to its issuance has been filed with the Director of Insurance. ( )

04. Preliminary Report. A binder of insurance, a commitment to insure, a preliminary report of title, and litigation reports including quiet title action, foreclosure actions of contracts of sale, deeds of trust or mortgages where a policy of title insurance will be issued on the successful completion thereof. Excluded are miscellaneous reports which do not insure title, such as judgment reports, lot book reports or property search reports which are governed by Subsection 012.01. ( )

05. Producer of Title Business. Includes any person engaged in this state in the trade, business, occupation or profession of: ( )

a. Buying or selling interest in real property; or ( )

b. Making loans secured by interest in real property; and ( )

c. May include but not be limited to real estate agents, real estate brokers, mortgage brokers, lending or financial institutions, builders, attorneys, developers, sub-dividers, auctioneers engaged in the sale of real property, consumers, and the employees, agents, representatives, or solicitors of any of the foregoing; and ( )

d. Will include any legal entity whose ownership is, directly or indirectly, comprised fifty-one percent (51%) or more by entities or individuals described in Paragraph 010.05.c of this rule. ( )

06. Title Examination. A search and examination of the title and a determination of insurability of the

title in accordance with sound title underwriting practices. Such examination of the public records will be made only for the purpose of determining insurability of the described property and not be a report on the condition of the record. ( )

07. Issuance of a Policy. The preparation, execution and delivery of a title insurance policy which is deemed to be only a contract of insurance up to the face amount of such policy and will in no way create a tort liability as to the condition of the record insured from. The same will include any necessary investigation just prior to actual issuance of a policy to determine if there has been proper execution, acknowledgment and delivery of any conveyances, mortgage papers, and other title instruments which may be necessary for the issuance of a policy. It will also include determination of the status of taxes based on the latest available information and a final search of the title and that all necessary papers have been filed for record. Issuance of the policy will not include services which are essentially escrow or closing services, such as receiving and disbursing money, prorating insurance and taxes, etc., for which an escrow fee will be charged. The issuer of the policy may specify requirements necessary for the issuance of the title insurance, but it is the responsibility of the applicant to meet such requirements and the title insurance agent will not act for the applicant to satisfy the same. It is not the responsibility of the policy issuer to cure defects of title or remove liens or encumbrances. Title insurers and title insurance agents issuing title insurance policies will not do any acts which constitute the practice of law and the premium will not include the cost of legal services to be performed for the benefit of anyone other than the company. A title insurance agent who is also a licensed lawyer rendering any legal services in the transaction insured will render a separate legal billing and the escrow fees will not include such legal services. ( )

08. Self-Promotional. A promotional function conducted by a single entity or a promotional item intended for distribution by a single entity. All benefits from the promotional function or item will accrue to the entity promoting itself. ( )

09. Items of Value. Anything that has a monetary value and includes, but is not limited to, tangible objects, services, use of facilities, monetary advances, extension of lines of credit, creation of compensating balances, and all other forms of consideration. ( )

10. Trade Association. An association of persons, a majority of whom are producers of title business, or persons whose primary activity involves real property. ( )

12. Title Entity. Includes both title insurance agents and title insurers and their employees, agents, or representatives. ( )

13. Definitions Pertaining To Collected Funds: ( )

a. Business Day means a calendar day other than Saturday or Sunday, and also excluding most major holidays. If January 1, July 4, November 11, or December 25 fall on a Sunday, the next Monday is also excluded from the definition of a business day. ( )

b. Collected Funds means (i) cash (currency); (ii) wired funds when unconditionally received by the escrow agent; (iii) when identified as such, (1) cashier's check; (2) certified check; or (3) teller's check (official check) when any of the above are unconditionally received by the escrow agent; (iv) U.S. Treasury checks, postal money orders, federal reserve bank checks, federal home loan bank checks, State of Idaho and local government checks, local or Idaho on-us checks, or local third party checks on the next business day after deposit; (v) local personal or corporate checks on the second business day after deposit; and (vi) non-local State and government checks, non-local on-us checks, non-local personal or corporate checks or non-local third party checks on the fifth business day after deposit. For purposes of this section a deposit is considered made on (1) the same day the item is delivered in person to an employee of a federally insured financial institution, or (2) the first business day following an after business hours deposit of an item to a federally insured financial institution. ( )

c. Cashier's Check, Certified Check and Teller's Check (Official Check) as identified above in Subsection 010.13.b. means checks issued by a federally insured financial institution. ( )

d. Local Checks: Checks drawn against a federally insured financial institution located in the same check processing region as the title agent's depositary federally insured financial institution. ( )

e. On-us checks: Checks drawn against the same federally insured financial institution or branch as the title agent's own depositary federally insured financial institution. ( )

f. Collection or Long-Term Escrow means an escrow established for the purpose of receiving two (2) or more periodic payments over a total period of time after establishment in excess of thirty (30) days. ( )

g. Escrow includes any agreement (express, implied in fact or at law) pursuant to which funds or documents are delivered to an escrow agent for holding until the happening of a contingency or until the performance of a condition, and then delivered by the escrow agent to another or recorded by the escrow agent. ( )

h. Escrow Agent includes any person or entity described in Section 41-2704, Idaho Code, (and the rules promulgated thereunder), which accepts funds or documents for the purpose described in Subsection 010.13.g. ( )

i. Incidental Expenses: Direct expenses that are the obligation of one or more of the parties to an escrow transaction but are not the purchaser's principal obligation. Incidental expenses would include, but not be limited to, advances to cover unexpected recording fees and additional interest caused by delays in closings or miscalculations. ( )

011. TRACT INDEXES OR ABSTRACT RECORDS.

For clarification and guidance, the following is considered to be the correct definition or meaning of "a complete set of tract indexes or abstract records" as used in Section 41-2702, Idaho Code: A set of indexes from which the record ownership and condition of title to all land within a particular county can be traced and ascertained. Tract indexes and abstract records will be maintained and posted to current date and will include adequate maps that will enable a person working the title plant to locate a tract of land that is the subject of the title examination. The basic component parts of such a set of indexes are: ( )

01. Basic Component Parts. An index or indexes, to be complete from the inception of title from the United States of America, in which the reference is to geographic subdivisions of land, classified according to legal description, (as distinguished from an index or indexes in which the reference is to the name of the title holder, commonly called a grantor-grantee index) wherein notations of or references to: ( )

a. All filed or recorded instruments legally affecting title to particularly described parcels of real property and which impart constructive notice under the recording laws; and ( )

b. All judicial proceedings in the particular county legally affecting title to particularly described parcels of real property are posted, filed, entered or otherwise included in that part of the indexing system which designates the particular parcel of real property; provided, no reference need be made in such index to any judicial proceeding which is referred to or noted in the name index defined in Subsection 011.02 of these rules. ( )

c. No requirement is made for taxes and assessments, water or otherwise, or for water and mineral rights, land use regulations, and zoning ordinances to be made a part of the plant records. ( )

02. Name Index or Indexes. A name index or indexes wherein notations of or references to all instruments, proceedings and other matters of record in the particular county which legally affects or may legally affect title to all real property (as distinguished from particularly described parcels of real property) of the person, partnership, corporation or other entity named and affected, including guardianships, absentee, bankruptcies, receiverships, divorces and mental illness matters, if available, are posted, filed, entered or otherwise included in that part of the indexing system which designates the same. ( )

03. Index Maintenance. The indexes prescribed in Subsection 011.01 may be maintained in bound books, looseleaf books, jackets or folders, on card files, or in any other form or system, whether manual, mechanical, electronic or otherwise; or in any combination of such forms or systems. ( )

04. Subdivision or Refinement. The extent to which the prescribed indexes are subdivided or refined is dependent upon all relevant circumstances. The population of the particular county, the extent to which land within

the particular county has been subdivided and passed into separate ownerships, and all other factors which are reasonably related to the purpose of the statutory requirements are entitled to consideration in such determination. ( )

05. Discarding or Destroying. Any requirement established in this rule to the contrary notwithstanding, it is permissible to discard and destroy prior index books, jackets, folders, cards, photoprints or files pertaining to recorded instruments affecting title to particularly described parcels of real property once the titles to such particularly described parcels have been searched, examined and a policy of owner's title insurance issued thereon. The discarding and destruction of prescribed index components is applicable only when a permanent copy of the search notes, examiner's opinion and issued policy is retained in lieu of the discarded and destroyed index components. ( )

012. PROCEDURAL RULES.

01. Miscellaneous Reports. Where an insurer or its agent issues judgment reports, lot book reports or property search reports, each such report will specifically contain the following statement: "This report is based on a search of our tract indexes of the county records. This is not a title or ownership report and no examination of the title to the property described has been made. For this reason, no liability beyond the amount paid for this report is assumed hereunder, and the company is not responsible beyond the amount paid for any errors and omissions contained herein." ( )

02. Special Exceptions. An insurer may insert such special exception(s) as may develop from an examination of the title. A special exception will specifically describe the item excepted to and will not be general in terms. The printed provisions of a filed policy form, including exclusions from coverage, exceptions not insured against and stipulations and conditions will not be deemed special exceptions. ( )

03. Liens and Encumbrances, Standards of Insurability and Insuring Around. The determination of insurability as to liens and encumbrances under Sections 41-2708(1) and the risk disallowed under 41-2708(2), Idaho Code, intentionally omitting an outstanding enforceable recorded lien or encumbrance, are interpreted by the insurance director to mean: ( )

a. "Intentionally" omitting an outstanding enforceable recorded lien or encumbrance is the issuance of the policy with the intent to conceal information from any person by suppressing or withholding title information, the consequence of which could result in a monetary loss either to the title insurance company or to the insured under the policy or binder. ( )

b. "Outstanding enforceable recorded lien or encumbrance" and/or "determination of insurability" as to possible liens and encumbrances will not be construed as preventing an insurer from issuing a policy without taking exception to a specific recorded, inchoate, or death tax item when sound underwriting standards and practices allow insurance against the item. Defects of title are not regulated by this provision. Specifically, a policy may be issued without taking exception to the following items on the conditions set out: ( )

i. Where a lien securing an obligation, though not released of record, to the satisfaction of the insurer has been discharged and the insurer or its agent has documentary evidence in its file that the obligation has been paid in full. ( )

ii. Where funds are in escrow to pay said item and a recordable release in form for filing is available for recording in the ordinary course of business. ( )

iii. Where liens, in the opinion of counsel, are barred by the statute of limitations. ( )

iv. Where inchoate liens may arise from improvements to the described property and may have priority over a mortgage being insured and a sufficient indemnity defined has been delivered to and accepted by the insurer, or sufficient funds, including short term treasury bills and notes, have been deposited with the insurer or its agent to assure ultimate payment and release of such liens; provided, an exception as to such inchoate liens will be shown on the policy with a provision insuring against enforcement. Sufficient indemnity as used herein will mean a direct obligation to pay such liens in an amount judged adequate by the insurer executed by a financial institution

regulated by the state or federal government or executed by a responsible person as hereinafter defined. This subsection will also apply to recorded liens being contested if the indemnity is one hundred and fifty percent (150%) of the claim and is by such financial institution or in said funds. ( )

v. Where the insurer has previously issued a policy without taking exception to the specific item and is called upon to issue an additional policy where it is already obligated under such prior policy and where the new policy will not increase its liability or exposure; provided, an exception as to such item will be shown on the policy with a provision insuring against the enforcement thereof. ( )

vi. When the mortgage policy issued insures validity and priority of a lien, the insurer need not itemize liens which are subordinate to the lien insured, whether by express subordination or operation of law, unless such subordinated matters are shown to comply with a policy provision, or unless requested by the insured to do so; provided, when issuing a preliminary report, commitment or a binder for a mortgagee's policy all subordinate liens will be shown but a statement may be made that they are subordinate. ( )

vii. With reference to federal estate taxes and state inheritance taxes which have not been paid, where the insurer has examined a balance sheet of the estate and determined more than adequate funds are on hand to pay such taxes, and the insurer has taken an indemnity from a responsible person protecting itself against such unpaid taxes, or where sufficient moneys or other securities to pay such taxes have been placed in escrow pending the payment thereof or pending receipt of waiver of lien from the taxing authority. ( )

viii. "Responsible person" is one (1), or more than one (1) if they are jointly and severally liable, each of whose current verified balance sheet upon examination is determined by the insurer to be sufficient for the purpose of the indemnity given. Verified copies of all statements will be retained by the insurer or its agent. ( )

04. Mechanics' Liens, Disallowed Risk. Under the provisions of Section 41-2708, Idaho Code, the Insurance Director has determined under standards of insurability, disallowed risks and rebates, that under all forms of mortgage policies the risk insured will not include unrecorded liens and encumbrances, including contractors', subcontractors' professional services, materialmen's and mechanics' liens, unless: ( )

a. The mortgage will have been placed of record prior to commencement of any improvement on the premises and the insurer is satisfied that the mortgage and related documents with reference to such priority; or ( )

b. Unless the provisions of Subsections 012.03.b.ii., 012.03.b.iii. or 012.03.b.iv., and 012.03.b.viii. as applicable have been complied with; or ( )

c. Unless the insurer has satisfied itself and documented its file that construction has been completed and the time for filing liens has expired. ( )

05. Usury, Truth in Lending Disclosures. Protection against usury, or disclosures prescribed in consumer credit protection acts, truth in lending acts, or similar acts imposing duties on lenders, do not constitute a part of the issuance of title insurance policies. Title insurers and their agents will not prepare or pass judgment on documents as to usury nor on disclosure documents and notice of right of rescission documents demanded by any such acts or make any computations as essential therein, in the issuance of title insurance policies; provided, an endorsement to a mortgage policy insuring that the loan is one by definition of the Truth in Lending Act exempt from rescission is permissible. Nothing herein will prevent such title insurers or their agents from performing closing or escrow services involving such matters when a proper fee is obtained therefor. ( )

06. Filing, Approval, Unique Contract or Rate. Whenever a title insurer is requested to insure a unique kind or class of risk for which a premium rate or form of policy or endorsement has not been filed, neither of which lends itself to an advance filing and determination of said rate or form, pursuant to Section 41-2706(4), such title insurer may make a written application to the Director of Insurance for approval of said special rate or form without complying with the filing notice and thirty (30) day waiting provisions of Section 41-2707 upon complying with the following requirements: ( )

a. The insurer has not agreed to the special rates, nor agreed to issue the special policy or

endorsement, prior to making an application to the Director of Insurance. ( )

b. The insurer will make a written application to the Director of Insurance, requesting approval of the applicable special rate or special insurance policy or endorsement, wherein the insurer will set forth why the particular rate or policy or endorsement is unique as to the risk or form, that such item has or has not ever arisen in the past five (5) years to the knowledge of said insurer, and the circumstances if it has previously arisen in said period, and the circumstances which now arise which necessitate said rate, policy or endorsement and an analysis comparing said unique rate, policy or endorsement to the nearest comparable filed rate, policy or endorsement and justifying the difference on the basis of Sections 41-2706(1) and (2), Idaho Code. Such application will have attached to it the proposed policy or endorsement form. The Director of Insurance will have ten (10) working days after the date of receipt of such application to disapprove the same, and the filing will be deemed effective if the same is not disapproved within such time. The burden is upon the insurer to make inquiry after the expiration after said ten (10) days to determine whether a disapproval has been made, whether or not mailed notice of such disapproval has not yet been received by said insurer. ( )

c. These provisions are only applicable to rates, policies and endorsements, which by reason of the rarity of the event, or the peculiarity of the circumstances, do not lend themselves to a general advance determination and filing of said item. Applications under this rule and the applicable statute will not be approved if it appears either that said application does not meet the standards of the statute or is such a deviation from the usual policy form or rate most nearly applicable thereto as to be an unsound underwriting practice or an inadequate premium. ( )

013. PREMIUM RATES AND THEIR APPLICATION.

01. Schedule of Premium Rates. Each title insurer will file its schedule of premium rates (including both the taxable risk portion and the service portion) for title insurance charged the public for all policies, which premium rates commence with the lowest rate and advance by one thousand dollars ($1,000) increments. The rate schedule will include owner's, standard mortgagee and extended coverage mortgagee policies, and may include other rates. In addition, any charges made for special endorsements will be listed and the type of policy to which applicable. Filed rates will provide that where a preliminary report is issued, the order for the policy may be canceled prior to closing. The applicant may be requested to pay a cancellation fee. The premium rates for policies will only include title examination and issuance of title insurance which will be deemed to include any preliminary report, commitment to insure, binder or similar report (herein collectively called preliminary report) and the policy subsequently issued thereon. If more than one (1) chain of title is involved, an additional charge will be made for each additional chain. An additional chain is one involving property in a different block or section or under a different ownership within the last five (5) years. ( )

02. Issuing Binders, Commitments or Preliminary Reports. No title insurer or title insurance agent will issue a title insurance binder, commitment or preliminary report without an order. ( )

03. Amount of Owner's Policy. An owner's policy will be issued for not less than (a) the amount of the current sales price of the land and any existing improvements appurtenant thereto, or (b) if no sale is being made, the amount equal to the value of the land and any existing improvements at the time of the issuance of the policy. If improvements are contemplated, the amount may include the cost of such improvements immediately contemplated to be erected thereon with a following pending improvement clause set forth in Schedule B of said policy and the full premium collected, which clause reduces the policy amount to the extent the improvements are not completed. The amount of policies covering leasehold estates for a term of fifty years or more will be for the full value of the land and existing improvements, and for less than fifty years will be for an amount at the option of the insured based on either the total amount of the rentals payable for the primary term but not less than five (5) years, or the full value of the land and existing improvements together with any improvements immediately contemplated to be erected thereon. The amount of policies insuring contract purchasers will be for the full value of the principal payments. Insurance of lesser estates will be written for the amount of the value of the estate at the time the policy is issued. ( )

04. Amount of Mortgagee Policies. A mortgagee's policy will be for not less than the full principal debt of the loan insured and at insured's request may include up to twenty percent (20%) in excess of the principal debt to cover interest, foreclosure costs, etc. Where the land covered represents only part of the security for the loan, the policy will be written for the amount of the unencumbered value of the land or the amount of the loan, whichever is the lesser. ( )

05. Simultaneous Issuance of Owner's and Mortgagee's Policy. When an owner's policy and a mortgage policy covering identical land are simultaneously issued, the owner's policy will bear the regular owner's rate. Premium for the mortgagee policy simultaneously issued may be for an amount less than the full mortgagee rate for the amount of insurance not in excess of the owner's policy. ( )

06. Double Sale and Reissue. No order will be held open to cover a double sale and the premium will be charged and the policy issued on each sale, unless the conveyance on resale is recorded at the same time as the original transaction. A title insurer may file an owner's reissue rate of not less than fifty percent (50%) of the basic rate which will be applicable to any policy ordered within two (2) years of the effective date of a prior owner's or purchaser's policy naming applicant as the insured provided that the following conditions are met: ( )

a. The prior policy or a copy thereof is presented to the issuing company and will be retained in the issuing company's file, or in the absence thereof, reasonable proof of issuance is provided the issuing company. ( )

b. The reissue premium will be based on the schedule of fees in effect at the time of reissue. ( )

c. Increased liability is to be computed in accordance with the basic schedule of fees in the applicable brackets. ( )

07. Amount on Litigation and Foreclosure Reports. Where a preliminary report is made for an owner's policy to be issued after a quiet title action or after a foreclosure of contracts of sale, deeds of trust or mortgages, the premium charge will be that on an owner's policy and the policy will be issued following the successful completion of the litigation or the foreclosure. A cancellation fee may be charged if the action is unsuccessful. Each such preliminary report will bear on its face as the limit of liability of the insurer, the value upon which the premium charge is based. ( )

014. DISCLOSURE BY PRODUCER OF TITLE BUSINESS.

01. Disclosure of Financial Interest. No title entity may accept any order to issue a title commitment, guarantee, title insurance policy for, or provide services including, but not limited to, escrow closing and foreclosure services, to an applicant if it knows or has reason to believe that the applicant was referred by a producer of title business, where the producer of title business has a financial interest in the title entity to which the business is referred unless the producer of title business has disclosed to the applicant the financial interest of the producer of title business. The disclosure will be made in writing and contain the items prescribed in Subsection 014.02 of this rule. ( )

02. Disclosure Provided to Applicant. The disclosure will be provided to the applicant at the time the sale and/or purchase contract is entered into. A signed copy of the disclosure will be maintained by the producer of title business and provided to the title entity prior to, or simultaneously with, the placing or the order for a title insurance commitment or guarantee or escrow closing services. The title entity will maintain a copy of said disclosure for a minimum period of five (5) years. The disclosure will contain the following: ( )

a. A heading, in bold face, all caps, type font 14 or higher that states: “NOTICE OF FINANCIAL INTEREST IN TITLE ENTITY BY PRODUCER OF TITLE BUSINESS.” ( )

b. A statement in type 12 font or higher: “We call this interest to your attention for disclosure purposes. (Provide name of Producer of Title Business) has a financial interest in this title entity (provide title entity name). This financial interest may result in a conflict of interest in our representation of you. Accordingly, you are free to choose any other title entity which is licensed by the Idaho Department of Insurance in the county in which the property is located. A list of title insurers and title agents licensed in the county in which the property is located may be found by contacting the Idaho Department of Insurance.” ( )

c. A statement that the Applicant has read the aforementioned disclosure and chooses to have their transaction served by the Title Entity referred by the Producer of Title Business. The disclosure will contain the signature of all applicants along with the date the signature(s) was accomplished. ( )

015. FINANCIAL INTEREST NOTICE.

01. Financial Interest Notice to Director. A title entity will notify the Director of the Department the names and addresses of all producers of title business that have a financial interest in the title entity, including the financial interest held by the producer of title business and the date the financial interest was acquired. ( )

02. Notice Filing. The title entity will provide the financial interest notice to the Director of the Department prior to the granting of a title agent license and upon request for renewal of a title agent license. ( )

016. – 020. (RESERVED)

021. TITLE INSURANCE AGENTS AND EMPLOYEES ACTING AS ESCROW AGENTS.

01. Written Instructions. An escrow agent will not accept funds or papers into escrow without dated written instructions signed by the parties or their authorized representatives adequate to administer the escrow account and without receiving, at the time provided with the escrow instructions, sufficient funds and documents to carry out terms of the escrow instructions. Funds and documents deposited will be used only in accordance with such written instructions. If additional instructions are needed, the agent will obtain the consent of both parties, their representatives to the escrow or an order of a court of competent jurisdiction at the expense of the escrow parties. ( )

02. Notice of Conflict of Interest. An escrow agent will act without partiality to any of the parties to the escrow. An escrow agent cannot close a transaction where he has, directly or indirectly, a monetary interest in the subject property either as buyer or seller. If an escrow agent has a business interest in the escrow transaction other than as escrow agent, the relationship or interest will be disclosed in the written escrow instructions. After noting such interest, an additional statement will appear as follows: "We call this interest to your attention for disclosure purposes. This interest will not, in our opinion, prevent us from being a fair and impartial escrow agent in this transaction, but you are, nevertheless, free to request the transaction be closed by some other escrow agent." ( )

03. Closing Statement. On completion of an escrow transaction, the agent will deliver to each principal a written closing statement signed by the agent of each principal's account. The same will show all receipts and disbursements. Any charge made by and disbursements to the escrow agent will be clearly noted. A copy will be retained. ( )

04. Control of Funds. An escrow agent will maintain one or more trust accounts in a federally insured financial institution into which all escrow funds received will be deposited and from which there will be drawn escrow payments. No other funds will be commingled with such trust account. Escrow fees will not be drawn until the escrow is completely ready to close in accordance with the escrow instructions and will be withdrawn not later than the day on which the final disbursements are made for the escrow closing. ( )

05. Escrow Accounting Procedures. An escrow agent will maintain on a current basis (a) an escrow ledger with a separate numbered sheet for each escrow agreement and (b) an escrow liability control account. Disbursements will be posted from checks or other vouchers and each item, not the total of items, will be entered. Escrow liability control account will balance with the escrow ledger at all times and will equal the balance of funds in the trust accounts for escrows at the bank. Checks cannot be drawn against an escrow account without sufficient credit balance for the particular escrow existing at the time. Funds will not be transferred between escrow agents except by writing checks and receipts which are charged and credited respectively to accounts with the reason noted and the authority therefor. All services will be performed and the escrow account ready to close before any service or escrow fees may be charged and drawn from an escrow account (unless an escrow is a long term collection, and fees are payable monthly or annually). The escrow funds will be placed in the trust accounts for escrows and no other funds commingled therewith. All entries in any escrow account will be posted the date of the entry without regard of the date of posting, but all entries will be posted daily. ( )

06. Escrow Records. Each escrow agent will maintain in each escrow transaction: ( )

a. Evidence of all funds received including copies of all instruments, which will include pre-numbered cash receipts, copies of cashier's checks, wire transfer confirmations or evidence of unconditional payment of checks, as applicable; ( )

b. Complete evidence of all funds disbursed which will include check stubs or check copies, and wire instructions for all disbursements as applicable; and ( )

c. A final ledger sheet for each escrow transaction listing all items received and disbursed. All records will be available for audit, inspection and examination by the Director upon demand, and all records will be preserved for not less than six (6) years from the closing date of the escrow. ( )

07. Bond. Before a license will be issued to a title insurance agent, such agent will comply with the requirements for a bond pursuant to Section 41-2711. Such bond may be in the form that continues from year to year until canceled. In lieu of a bond, cash or securities as herein defined may be deposited with the Director of Insurance. The Director of Insurance approves the following securities which are eligible for deposit in place of the bond: Cash in the form of a cashier's check, any public obligation as defined in Sections 41-707 and 41-708, Idaho Code, and the assignment of any savings deposits or certificates of deposit as defined in Section 41-720, Idaho Code. In each case, such deposit will be accompanied by a statement that such deposit is made to meet the compliance of Section 41-2710, Idaho Code, and may be liquidated to meet the obligations of said section. Said cash or security in lieu of the bond will be deposited with the director pursuant to Section 41-804, Idaho Code, except that the cash will be deposited with the state treasurer for the account of the bond of said depositing agent. ( )

08. Cancellation of Bond. A title insurance agent's bond may provide for cancellation thereof upon notice of not less than thirty days to the Insurance Director and to the licensed agent. Upon such notice being received, the licensed title insurance agent will provide a new bond in place thereof before the cancellation of the current bond, and in the event of failure to do so, the license of the title insurance agent will be deemed suspended on the date of the expiration of such bond, and until a replacement bond has been issued and delivered to the Director of Insurance. ( )

09. Disbursement of Funds or Documents From Escrow -- Requirement for Collected Funds. ( )

a. Notwithstanding any agreement to the contrary, no disbursement of funds or delivery of documents from an escrow for recording or otherwise may be made unless the escrow contains a credit balance consisting of collected funds, other than funds of the escrow agent or its affiliates, sufficient to discharge all monetary conditions of the escrow. The requirement of collected funds does not apply to collection or long term escrows. ( )

b. Notwithstanding any other provision of Section 021, an escrow agent may advance its own funds in an aggregate amount not to exceed one thousand dollars ($1000) to pay incidental expenses incurred with respect to the escrow. ( )

022. ESCROW FEES.

Title insurers and title insurance agents will not charge less than the fees filed with the Department of Insurance for a specified escrow service, as such service is defined in the title insurer's or title insurance agent's filed schedule of fees. Each title insurer and title insurance agent will file its schedule of escrow fees charged for all escrow and closing services rendered on a yearly basis due March 15 reflecting experience from the previous calendar year. Fees should include a title entity's basic rate, minimum rate and negotiable rate with respect to different types of closings and should not reflect credits of any kind with regard to different classifications of customers. The fee will be based upon the full sales price in the event of a sale, or the amount of the loan in the event of a mortgage and will not be less than the title entity's cost for providing that service. Fees for escrow and closing services will not include preparation of instruments. Property in different ownerships always, and noncontiguous properties generally, are rated separately. Additional fees will be charged where the minimum fee is inadequate because of the unusual complications of the transactions. Fees may also be filed throughout the year as often as necessary as determined by the title entity. Fee filings in these instances will be filed at least thirty (30) days prior to implementation of the fees. ( )

023. -- 030. (RESERVED)

031. REBATES AND ILLEGAL INDUCEMENTS.

01. Items of Value. A title entity will not provide items of value to a producer of title business, consumer or member of the general public except as permitted in Sections 031.02, 031.03, 031.04 and 031.05 of this chapter. If a providing of things of value does not clearly fit into the rules in Sections 031.02, 031.03, 031.04, and 031.05, then it is not allowed. Exhibit 1, located on our website at https://doi.idaho.gov/, is a partial, but not all-inclusive, list of acts and practices that are considered illegal inducements disallowed by Title 41, Idaho Code. ( )

02. Permitted Consumer Information. To facilitate the listing and sale of Idaho property, certain consumer information may be provided without charge to licensed real estate agents and brokers or to a person who owns the property for which the request is made, but is limited to the following information: ( )

a. Listing Package is a single copy of a listing package, property profile, or similarly named packet of information and will consist of information relating to the ownership and status of title to real property, and may include a single copy of only the following seven (7) items: ( )

i. The last deed appearing of record; ( )

ii. Deeds of trust or mortgages which appear to be in full force and effect; ( )

iii. A plat map reproduction and/or a locater map; ( )

iv. A copy of applicable restrictive covenants; ( )

v. Tax information; ( )

vi. Property characteristics such as number of rooms, square footage and year built; and ( )

vii. Photographs, including aerial, of the property. ( )

b. A listing package may include no more than the seven (7) above described items of information and will not include market value information, demographics, or additions, addenda, or attachments which may be construed as conclusions reached by the title entity regarding matters of marketable ownership or encumbrances. Photographs may be provided, but only if the title entity does not pay a separate fee or provide any other consideration to a person for that product or service. The title entity may provide any photographs that are acquired through normal subscriptions or licensing fees associated with obtaining access to county records for tax information, property characteristics, or plat maps, as long as there is no additional charge to the title entity for the production, reproduction or delivery of the photographs. A generic cover letter with the printed standard letterhead of the title entity may be attached to the listing package. The cover letter may include a brief statement identifying by name only, which of the seven (7) permitted items of information are attached thereto. The cover letter may also contain a disclaimer as to conclusions of marketable ownership or encumbrances. The content of the cover letter or listing package is strictly limited to the foregoing and will specifically not include any advertising or marketing for the benefit of the recipient. ( )

c. Market value information, demographics, additions, addenda, photographs (other than as described in Paragraph 031.02.b) or other attachments, which attachments may be construed as conclusions reached by the title entity regarding matters of marketable ownership or encumbrances, may be provided, but only upon receipt of a charge commensurate with the actual cost of the work performed and the material furnished. ( )

d. A title entity may provide to licensed attorneys and licensed appraisers only the following documents without charge; ( )

i. A plat map reproduction; ( )

ii. A copy of applicable restrictive covenants; ( )

iii. The last deed appearing of record; and ( )

iv. A cover letter as described in Paragraph 031.02.b. ( )

03. Advertising With Trade Associations. ( )

a. No advertisement may be placed in a publication that is published or distributed by, or on behalf of, a producer of title business. Advertising in a trade association publication is only permitted if the publication is an official publication, published or distributed by, or on behalf of the trade association with at least regular annual publications. The publications should be nonexclusive (any title entity will have an equal opportunity to advertise in the publication and at a standard rate). The title entity's ad will be purely self-promotional. ( )

b. A title entity is permitted to donate time to serve on a trade association committee and may also serve as an officer or director for the trade association. A title entity may also donate, contribute or otherwise sponsor a trade association event if the event is a recognized association event that generally benefits all members and affiliated members in an equal manner. The donation cannot benefit selected producer of title business members of the association unless through random process. Solicitation for the donation should be made of all members and affiliated members in an equal manner. Donations are per agent license or insurer and are limited to a cumulative donation value of two thousand dollars ($2,000) or equivalent things of value collectively to all trade associations per year. In addition, a title entity is allowed to participate in or attend trade association events as long as the title entity pays a fee commensurate with fees paid by other participants in the events. These events include, but are not limited to, conventions, award banquets, symposiums, breakfasts, lunches, dinners, open houses, sporting activities and all other similar activities. ( )

04. Self-Promotional Advertising. ( )

a. A title entity may distribute self-promotional items having an acquisition value of less than twenty-five dollars ($25) to producers of title business, consumers, and members of the general public. These self-promotional items are limited to novelty gifts, advertising novelties, and generic business forms and specifically do not include food, beverages, gift certificates, gift cards, or other items that have a specific monetary value on their face or that may be exchanged for any other item having a specific monetary value. Self-promotional items will not contain the name, logo or any reference to a producer of title business, trade association or donee. ( )

b. Self-promotional functions are limited to the following two (2) types of functions: ( )

i. A title entity is permitted to conduct educational programs. The education programs will only address title insurance and escrow and other topics related thereto. A title entity is permitted to expend no more than twenty dollars ($20) per person at an educational program. For purposes of determining the maximum permitted expenditure, all costs associated with the delivery of the educational program is considered, including but not limited to, costs paid by the entity for travel, refreshments, instructor or speaking fees and facility rental. A title entity may participate in or make presentations at educational programs which are conducted or presented by other entities. The title entity is not permitted to expend any money to sponsor or cosponsor these programs, unless the educational program is a trade association event in which case Subsection 031.03.b of this chapter will apply. ( )

ii. A title entity is permitted to have two (2) open houses per year. An open house is a self-promotional function at the title entity's owned or occupied facility (i.e. a Christmas party or any party, an open house for remodeling of its facility, an open house for a new building to become the title entity's facility). It is nonexclusive (all producers of title business are invited). A title entity will not expend more than fifteen dollars ($15) per guest per open house. A title entity cannot combine permitted expenditures for two (2) open houses to be used for one (1) open house. A title entity also cannot accumulate left over or unused expenditures from one (1) open house and use those expenditures for a second open house. ( )

05. Permitted Business Entertainment. A title entity will not expend more than one hundred dollars ($100) per person per day for all meals and/or events. Meals and events will include, but not be limited to, breakfast, brunch, lunch, dinner, cocktails, sporting events, sporting activities, trips and music and art events. These meals or events may occur on or off the title entity's premises. In addition, a title entity may entertain no more than four (4)

persons who are employed by or agents of any single producer of title business in a single day. Spouses and/or guests of the producers of title business or employees or agents are included in the count for purposes of determining the four (4) person maximum. In addition, a person cannot be entertained by a title entity more than three (3) days during any ten (10) day period of time. For purposes of determining the maximum permitted expenditure, all costs associated with any meals or events will be considered. This will include, but not be limited to, costs paid by the title entity for travel, transportation, hotel, equipment or facility rental, meals, cocktails, refreshments, registration or entry fees and event tickets. Entertainment permitted under this rule cannot be conditional upon or compensation for forwarding or directing title business to the title entity. ( )

06. Locale of the Title Insurer or Title Insurance Agent Employees. A title entity will not have any of its employees working in a work space location owned or leased by a producer of title business unless: ( )

a. The space is secured by a bona fide written lease or rental agreement. ( )

b. The space is separate from and can be secured against access by other occupants of the premises. ( )

c. The rental paid for the workspace is consistent with prevailing rental payments for similar space in the market area of the location of the work space. ( )

d. The rental is not dependent on volume of business and is paid only in cash (rental cannot be paid by trade or barter). ( )

e. The space is open to the conduct of business with any producer of title business or consumer. ( )

f. There is no sharing of employees. ( )

g. There is no common usage of space or equipment between the title entity and the producer of title business without a proportionate share of cost, rent, or expense paid by each party. ( )

07. Penalty. This Section emphasizes and restates the general penalties authorized pursuant to Title 41, Idaho Code, for violations of the anti-rebate and anti-illegal inducement laws. ( )

a. Section 41-2708(3), Idaho Code, provides that each person and entity giving or receiving a rebate, illegal inducement, or a reduction in rate is liable for three (3) times the amount of such rebate, illegal inducement, or reduced rate. In addition to this penalty, a title entity may also be subject to an administrative penalty as outlined below. ( )

b. Section 41-327, Idaho Code, provides that the Director may impose an administrative penalty not to exceed five thousand dollars ($5,000) and/or suspend or revoke an insurer's certificate of authority if the Director finds, after a hearing thereon, that the insurer has either violated or failed to comply with the Insurance Code. ( )

c. Section 41-1016, Idaho Code, provides that the Director may impose an administrative penalty not to exceed one thousand dollars ($1,000) and/or suspend or revoke an agent's license if the Director finds, after a hearing thereon, that the agent has either violated or failed to comply with the Insurance Code. ( )

032. DISSEMINATION.
All title entities are instructed to distribute a copy of this rule to every employee that may be engaged in activities requiring knowledge of its contents, and to instruct all employees in its scope and operation. ( )

033. -- 999. (RESERVED)

18.06.01 – RULES PERTAINING TO BAIL AGENTS

000. LEGAL AUTHORITY.
Title 41, Sections 41-211 and 41-1037 through 41-1045, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.06.01, "Rules Pertaining to Bail Agents." ( )

02. Scope. The provisions of this rule apply to all bail agents, as defined by Section 41-1038, Idaho Code. This rule is supplementary to other rules and laws regulating insurance producers, and all other rules of the Department and provisions of Title 41, Idaho Code, applicable to insurance producers apply to bail agents. ( )

002. -- 011. (RESERVED).

012. NOTIFICATION REQUIREMENTS.

01. Notice of Changes. A bail agent licensed pursuant to Section 41-1039, Idaho Code, will immediately notify the Department in writing of any the following: ( )

a. Change of bail agent's name, current business address, or current business phone number or business e-mail address, if any; ( )

b. Change of name or address of any surety insurance company for which the bail agent has an active appointment; ( )

c. Cancellation by a surety insurance company of a bail agent's authority to write bonds for that company; ( )

d. Any new affiliation with a bail bond agency; ( )

e. Cancellation of a bail agent's affiliation with a bail agency; ( )

02. Notice of Legal Proceedings. A bail agent will provide immediate written notice to the Department of the filing of any criminal charges against the bail agent. A bail agent will also provide immediate written notice to the Department of any material change in circumstances that would require a different answer than previously provided by the bail agent on the background information section of the Uniform Application for Individual Insurance Producer License/Registration. ( )

013. CRIMINAL HISTORY CHECKS.

01. Criminal History Check Requisite. All licensed bail agents will obtain a criminal history records check in connection with the renewal of a bail agent's license and will bear all costs associated with the records check. ( )

02. Grounds for Immediate Suspension. For the purpose of determining whether grounds for immediate suspension of a bail agent's license exist under Section 41-1039(4), Idaho Code, a withheld judgment or a plea of nolo contendere is considered the same as a conviction or guilty plea. ( )

014. STACKING OF BONDS.
A bail agent may submit only one (1) power of attorney with each bail bond submitted to any Idaho court. The face value or face amount of the power is equal to or greater than the amount of the bail or bond set by the court in the case for which the bond and power are being submitted. ( )

015. NOTIFICATION TO SURETY OF FORFEITURE.
A bail agent will notify the surety insurance company of any forfeiture, as defined in Section 19-2905, Idaho Code, within ten (10) days of receiving the notice from the court. ( )

016. (RESERVED)

017. BAIL AGENT FINANCING OF BAIL BOND PREMIUMS.

01. Written Agreement. No credit may be extended by any bail agent or surety insurance company for

the payment of any bail bond premium without entering into a written agreement. The written agreement for the extension of credit to finance premium need to contain at a minimum the following: ( )

a. The name, signatures, and dates of signatures of all parties to the credit agreement; ( )

b. The amount of premium financed; ( )

c. The per annum rate of interest; and ( )

d. The scheduled premium payment dates. ( )

02. Early Surrender for Failure to Pay. If failure to pay premiums due under a credit arrangement may result in the early surrender of the defendant, that fact needs to be clearly set forth in the written credit agreement. Early surrender for failure to make premium or interest payments when due is to be handled in accordance with Section 41-1044, Idaho Code, and neither the bail agent nor the surety is entitled to seek recovery of any amounts unpaid as of the date of surrender. ( )

03. Collateral for Credit Agreement. If the credit agreement is to be collateralized, the collateral will not be excessive in relation to the amount of premium financed, will be separate and apart from any collateral used in the bail bond transaction, will be described in the credit agreement or in an attachment to the agreement, and will be handled in accordance with Section 41-1043, Idaho Code. ( )

018. PAYMENT OF FORFEITURE.

It is a violation of Section 41-1329(6), Idaho Code, for a bail surety to fail to pay a claim for forfeiture after liability for payment has become reasonably clear. Liability for payment upon forfeiture is reasonably clear when a defendant has not appeared or has not been brought before the court within one hundred eighty 180 days after the entry of the order of forfeiture, or a motion to set aside the forfeiture, in whole or in part, has not been filed with the court within five (5) business days after the expiration of the one hundred eighty (180) day period following the order of forfeiture pursuant to the Idaho Bail Act. ( )

019. -- 999. (RESERVED)

18.06.02 – PRODUCERS HANDLING OF FIDUCIARY FUNDS

000. LEGAL AUTHORITY.
Title 41, Chapter 2 and 10, Sections 41-211, 41-1024, and 41-1025, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.06.02, "Producers Handling of Fiduciary Funds." ( )

02. Scope. This rule will affect "producers," including bail agents who handle funds held in a fiduciary capacity. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Cash Collateral. All funds received as collateral by a producer in connection with a bail bond transaction in the form of cash, check, money order, other negotiable instrument, debit or credit card payment, or other electronic funds transfer, given as security to obtain a bail bond, as referenced in Section 41-1043, Idaho Code. ( )

02. Fiduciary Fund Account. A financial account established to hold fiduciary funds as provided in Section 016. ( )

03. Fiduciary Funds. All premiums, return premiums, premium taxes, funds as collateral, and fees received by a producer. Fiduciary funds include: ( )

a. All funds paid to a producer for selling, soliciting or negotiating policies of insurance except for those fees recognized by statute as earned by the producer upon receipt which are payable to the producer and not the insurance company, pursuant to Section 41-1030, Idaho Code. ( )

b. All funds received by a producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or to the producer's employer. ( )

c. All funds provided to a producer by an insurance company or its agents that are to be paid to a policyholder or claimant pursuant to a contract of insurance. ( )

d. All checks or other negotiable instruments collected by the producer and made payable to the insurer. ( )

e. Cash collateral. ( )

04. Receive. To collect or take actual or constructive possession of fiduciary funds. Receiving, includes but is not limited to, taking possession of money, checks, or other negotiable instruments. If fiduciary funds are in the form of a credit or offset on an account or other liability for the benefit of the consumer, without the producer actually taking possession of the funds, then constructive receipt is presumed to have occurred on the due date to the insurer. ( )

011. -- 013. (RESERVED)

014. FIDUCIARY FUND ACCOUNT.

01. Payable to an Insurer. Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to an insurer as described in Subsection 010.03 are to be remitted to the insurer within the time period set forth in the insurer's terms and conditions, or if not specified, then within twenty-one (21) days of receipt. ( )

02. Payable to a Policyholder. Fiduciary funds that are in the form of a check or another negotiable instrument made payable to a policyholder or claimant as described in Subsection 010.02.c. are to be remitted to the policyholder or claimant within fourteen (14) days of receipt or as specified by the terms of the policy of insurance, the insurer, or applicable law. ( )

03. All Other Fiduciary Funds. All other fiduciary funds received by the producer, except as

described under Subsections 014.01 and 014.02 are to be deposited into a fiduciary fund account according to the following schedule: ( )

a. If in the form of cash, within seven (7) days of receipt, except that, when a producer holds fiduciary funds in the form of cash that exceed two thousand dollars ($2,000), such funds will be deposited within three (3) business days. ( )

b. If in the form of checks, money orders, other negotiable instruments, debit or credit card payments, or other electronic funds transfer, received or collected by the producer, within seven (7) days of receipt, except that the producer may remit such funds to the following: ( )

i. Another licensed producer or licensed business entity, subject to Subsection 014.03.b.; or ( )

ii. A person designated by the insurer who has the obligation to remit the fiduciary funds to the insurer subject to Subsection 014.03.b. ( )

04. Document the Receipt of Fiduciary Funds. A producer who receives fiduciary funds will document the receipt of those funds in sufficient detail to determine, at a minimum, the date received, the name of the payee, and the amount received. If the producer receives cash, including cash collateral, the producer will give the payer a detailed receipt at the time of payment. The receipt needs to indicate that cash was received, the date received, the amount received, the payer's name, the payee's name, the purpose of payment, and any other information important to the transaction. The producer will maintain the receipt for a period of at least five (5) years. ( )

015. DEPOSIT OF OTHER FUNDS IN ACCOUNT.
A producer may deposit other additional funds for the sole purpose of: ( )

01. Reserves for Return Premiums. Establishing reserves for payment of return premiums. ( )

02. Funds to Pay Bank Charges. Advancing funds sufficient to pay bank charges. ( )

03. Contingencies. For any contingencies that may arise in the business of receiving and transmitting premium or return premium funds or cash collateral (any such deposit is hereinafter referred to as "voluntary deposit"). ( )

016. TYPES OF ACCOUNTS PERMITTED.

01. Accounts in Federally Insured Financial Institutions. A producer will maintain the fiduciary funds only in checking accounts, demand accounts, savings accounts or other accounts in a federally insured financial institution. ( )

02. Exceed the Federally Insured Limits. If such funds held exceed the federally insured limits, then in addition to Subsection 016.01, those funds that exceed the federally insured limits may be deposited into the following: ( )

a. An investment account that invests monies in United States government bonds, United States Treasury certificates or in federally guaranteed obligations; ( )

b. Money market mutual funds registered with the SEC which are rated AAA by Moody's or AAA by S&P. ( )

03. Separate Fiduciary Funds Account. Nothing in this rule obligates a producer to maintain and hold fiduciary funds in his, her, or its, own separate fiduciary funds account. Each producer is responsible for compliance with the provisions of this rule even if fiduciary funds are maintained in a fiduciary funds account established by another affiliated producer. ( )

017. ACCOUNT DESIGNATION.

01. Designation of a Fiduciary Fund. A fiduciary fund account is so designated on the records of the financial institution. The account has a separate account number, a separate check register and its own checks. ( )

02. Trust Fund Account. The phrase, "Trust Fund Account" is displayed on the face of each check drawn on a fiduciary fund account or other similar designation as permitted by the financial institution to identify the checks as being from a fiduciary fund account. ( )

018. INTEREST EARNINGS.
A fiduciary fund account may be interest-bearing or an investment account in accordance with Section 016. The producer will maintain records establishing the existence and amount of interest accrued. ( )

019. PERMISSIBLE DISTRIBUTION OF FIDUCIARY FUNDS.
Distributions from a fiduciary fund account are to only be made for the following purposes, and in the manner stated: ( )

01. Remit Premiums. To remit premiums to an insurer or an insurer's designee pursuant to a contract of insurance; ( )

02. Return Premiums. To return premiums to an insured or other person or entity entitled to the premiums; ( )

03. Remit Surplus Lines Taxes and Stamping Fees. To remit surplus lines taxes and stamping fees collected to the appropriate state; ( )

04. Reimburse Voluntary Deposits. To reimburse voluntary deposits made by the producer to the extent that the funds in the fiduciary account exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous voluntary deposit. ( )

05. Transfer or Withdraw Accrued Interest. To transfer or withdraw accrued interest to the extent that fiduciary fund account funds exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous interest deposit by the financial institution. ( )

06. Transfer or Withdraw Actual Commissions. To transfer or withdraw actual commissions and those earned fees recognized as earned by the producer, upon receipt, which are payable to the producer, only if the commissions and fees can be matched and identified with funds previously deposited in the fiduciary account. ( )

07. Pay Charges Imposed. To pay charges imposed by the financial institution that directly relate to the operation and maintenance of the fiduciary funds account. ( )

08. Transfer Funds. To transfer funds from one (1) fiduciary fund account to another fiduciary fund account. ( )

09. Return Cash Collateral. To return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, has been discharged. ( )

10. Convert Cash Collateral. To convert cash collateral where the defendant or other responsible party fails to satisfy the obligation of the bail bond and the bail or obligation was not exonerated by the court but instead executed by the court, provided such conversion is compliant with the contract between the producer and the person who deposited the cash collateral. ( )

020. -- 021. (RESERVED)

022. TIMELY DISBURSEMENT OF FIDUCIARY FUNDS.

In addition to the requirements of Section 014, after receiving fiduciary funds, a producer: ( )

01. Remits Premiums. Remits premiums directly to an insurer or an insurer's designee within the time period set forth in the insurer's terms and conditions, or if not specified, within fourteen (14) days of receipt; ( )

02. Returns Money Received. Returns to the payer the money received as a premium deposit which is retained by the producer or returned to the producer by the insurer to the payer by the earlier of: ( )

a. Fourteen (14) days from the date the premium is received by the producer from the insurer, or ( )

b. Fourteen (14) days from the date the insurer notifies the insurance applicant that coverage has been denied if the producer retained the premium deposit. ( )

03. Refund Received from the Insurer. Issues a refund received from the insurer within fourteen (14) days by disbursing money to the insured or other party entitled thereto by notifying the insured that the refund is being applied to an outstanding amount owed or to be owed by the insured. If the producer is applying the refund to an outstanding amount owed by the insured, the producer obtains the insured's permission and provide the insured a detailed description of the amount owed to which the refund is being applied. ( )

04. Dispute of Entitlement of Funds. If there is a dispute as to entitlement of funds under Subsections 022.01 or 022.03, a producer notifies the parties of the dispute, seeks to resolve it, and documents the steps taken to resolve it. ( )

05. Funds Held for More Than Ninety Days. If fiduciary funds within the scope of Subsections 022.01 or 022.03 are held for more than ninety (90) days, the producer investigates to determine the entitlement to fiduciary funds and pays those fiduciary funds when due to the appropriate person in accordance with this section. ( )

06. Return Cash Collateral. Returns cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, is discharged. ( )

023. - 999. (RESERVED)

18.06.03 – RULES GOVERNING DISCLOSURE REQUIREMENTS FOR INSURANCE PRODUCERS WHEN CHARGING FEES

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Section 41-211, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.06.03, "Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees." ( )

02. Scope. This chapter applies to all resident and non-resident insurance producers who charge a fee to consumers as authorized by Section 41-1030, Idaho Code. ( )

002. -- 010. (RESERVED)

011. DISCLOSURE REQUIREMENTS.

01. Before Charging a Fee. Before charging a fee to a consumer, a retail producer will furnish to each consumer a written disclosure statement containing at least the following information: ( )

a. A description of the nature of the work to be performed by the insurance producer. ( )

b. The fee schedule and any other expenses that the insurance producer charges, and whether fees may be negotiated. ( )

02. Prior Information Disclosure. A retail producer will disclose information prescribed under this chapter to each consumer to whom a fee will be charged prior to engaging in any act for or on behalf of the consumer. ( )

03. Fee for Intended Services. A retail producer may charge a fee for those services intended to be provided and that are not contingent upon a future event occurring outside of the terms of the insurance contract. ( )

04. Non-Chargeable Fee. A retail producer will not charge a fee for services in connection with statutorily mandated insurance coverage. ( )

012. -- 999. (RESERVED)

18.06.05 – MANAGING GENERAL AGENTS

000. LEGAL AUTHORITY.
Managing General Agent Act (MGA Act), Title 41, Chapters 15 and 2, Idaho Code. ( )

001. TITLE AND SCOPE.
IDAPA 18.06.05, "Managing General Agents." This chapter implements and administers provisions of the MGA Act. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Applicability of Statutory Definitions. The definitions contained in the MGA Act as set forth in Section 41-1502, Idaho Code, apply. ( )

011. NOTICE PROVISIONS.

01. Notice by MGA. Upon licensure and, thereafter, on or before July 1 of each year, any person, firm, association or corporation acting in the state of Idaho in the capacity of an MGA as defined in Section 41-1502(3), Idaho Code, provides notice to the Director of the Department which includes: ( )

a. A certified copy of the surety bond prescribed by Subsection 013.01. ( )

b. Proof of insurance coverage as prescribed by Subsection 013.02. ( )

c. The appropriate nonrefundable designation fee prescribed by IDAPA 18.01.02. ( )

d. A list of all names and addresses of insurers doing business in the State of Idaho or Idaho domestic insurers with which the MGA has a contract and a verified statement on a form provided by the Department that the contract(s) contain the provisions prescribed by Section 41-1504, Idaho Code. ( )

02. Notice by Insurer. In addition to those items specified in 41-1505(5), notice by the insurer will include: ( )

a. The name and address of the MGA; ( )

b. Proof that the MGA has met the bonding and insurance requirements of Section 013; ( )

c. Procedures and timetable for conducting an onsite review of the underwriting and claims processing operation of the MGA as prescribed by Section 41-1505(3), Idaho Code; and ( )

d. The name of an officer of the insurer responsible for the contract. ( )

012. (RESERVED)

013. SECURITY PAYMENTS.

01. Bond. All MGAs acquire a surety bond for the protection of the insurer and insureds. The bond will be in the amount of fifty thousand dollars ($50,000) or ten percent (10%) of the amount of total funds handled within the preceding year, whichever is greater. The bond amount will be adjusted accordingly on or before July 1 of each year. Coverage cannot be written by the insurer or an affiliate of the insurer employing the MGA. ( )

02. Errors and Omissions Policy. All MGAs acquire and maintain an errors and omissions insurance policy providing for claims arising out of the MGA's negligent acts, errors or omission. The policy coverage limit is set at two hundred fifty thousand dollars ($250,000) or twenty-five percent (25%) of the gross amount of direct written premiums received by an insurer for the previous calendar year that are attributable to the MGA, whichever is greater. The policy coverage limit will be adjusted accordingly on or before July 1 of each year. Unless approved by the director, coverage will not be written by the insurer or an affiliate of the insurer employing the MGA. ( )

014. INDEPENDENT AUDIT OR EXAMINATION.

01. Annual Independent Audit of MGA. An independent audit by a certified public accountant is

conducted annually for MGAs currently under contract, and is to be contracted for by the insurer. The independent audit will include the following: ( )

a. Report of independent certified public accountant; ( )

b. Balance sheet; ( )

c. Statement of income; ( )

d. Statement of cash flow; ( )

e. Statement of income and retained earnings; ( )

f. Notes on financial statements - these notes are those prescribed by General Accepted Accounting Principals; and ( )

g. A copy of a management letter or a narrative statement setting forth what would have been the content of the management letter had such letter been completed. ( )

02. Examination of MGA. The Department retains authority to examine an MGA notwithstanding the termination of the MGA's contractual authority. Pursuant to the provisions of Title 41, Chapter 2, Idaho Code, the expense of such examination is to be reimbursed to the Department by the insurer employing the MGA. ( )

015. TERMINATION OF CONTRACT.

01. Notice to the Department. Notice of the termination of an agreement between an MGA and an insurer for which the MGA was conducting business in the state of Idaho will include the name of the person, firm, association or corporation acting as an MGA under the terms of the contract and the basis for the termination. ( )

02. Delivery of Records to Insurer upon Termination of Contract. If the contract between an insurer and an MGA is terminated for any reason, the MGA will, upon request by the insurer, deliver all records to the insurer within ninety (90) days of the request. ( )

016. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 12, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.06.06, "Surplus Line Rules." ( )

02. Scope. Provide procedures for the placement of surplus line insurance. ( )

002. – 009. (RESERVED)

010. DEFINITIONS.
In addition to the definitions set forth in Section 41-1213, Idaho Code, the following definitions also apply: ( )

01. Open Lines for Export. "Open Lines for Export" is defined as the class or classes of business which the Director has declared eligible for export in accordance with Section 41-1216, Idaho Code. ( )

02. Lines Other Than Open Lines for Export. **"**Lines Other Than Open Lines for Export" is defined as the class or classes of business not on the list of open lines for export which are to be offered to eligible surplus lines insurers in accordance with Title 41, Chapter 12, Idaho Code. ( )

03. Diligent Search. A Broker has exercised their obligations under Section 41-1214(2), Idaho Code, if the Broker or the referring insurance producer submits a risk to at least one (1) authorized company engaged in writing in Idaho the type of coverage sought, or if there are no companies engaged in writing such coverage, the risk is submitted to at least one (1) company that, in the Broker's or producer's professional judgment, is the most likely to accept the risk. ( )

04. Delegated Contractor. Any contractor to whom activities have been delegated by the Director under Section 41-1232, Idaho Code. ( )

011. BIENNIAL LICENSE.
The Idaho license of a resident or non-resident Broker is to be renewed every two (2) years. The original license fee and the renewal fee are prescribed in IDAPA 18.01.02. A broker will not solicit surplus line business before being licensed as a Broker. A broker will notify the Licensing Division of the Department if not renewing the license prior to the license renewal date. The Director may allow the continuation of a non-renewed license if, within one (1) year after the renewal date, the licensee submits a renewal request and a continuation fee twice the amount prescribed by Section 41-1008(3), Idaho Code. ( )

012. ANNUAL REPORT.
Each Broker will file an annual report with the Director by March 1st of each year, of Surplus Line business transacted during the previous calendar year on an approved form. ( )

013. PAYMENT OF STATE TAX.

01. Tax Due March 1. On or before March 1st of each year, each licensed Broker will pay premium tax to the Department on business written during the preceding calendar year, which tax will be collected from the insured, in addition to the stamping fee. ( )

02. Tax Summary. By February 1st of each year the delegated contractor will provide to each Broker a summary of records showing the state tax due the Department for the preceding year and this amount will be paid to the Department by the Broker. A flat percentage of the gross premium written during the year is not acceptable since tax was collected on each individual policy and that full amount will be paid to the Department. ( )

014. PAYMENT OF STAMPING FEES.

01. Application. A stamping fee is charged on all premiums and policy fees written on Idaho business at a rate established by the delegated contractor and approved by the Department. This rate may be adjusted to obtain the objectives of the delegated contractor. The stamping fee cannot be refunded except in the case of extenuating circumstances approved by the delegated contractor. ( )

02. Summary. Within ten (10) days following the month during which the surplus line insurance was handled through the delegated contractor, the delegated contractor will submit an invoice summarizing the premium, Idaho tax, and Stamping Fee for each submission processed to each Broker. ( )

03. Payable on Receipt. The Stamping Fee is payable upon receipt of billing. It is delinquent if not paid within thirty (30) days after the last day of the month in which the business was reported. ( )

015. COLLECTION OF TAXES.

01. Idaho Premium Taxes. Idaho Premium Tax will be collected from the insured. Policy fees, service fees, and other like fees are considered part of the premium and subject to premium tax. State premium taxes will be refunded to the taxpayer upon cancellation of the policy or return of premium for any reason. ( )

02. Purchasing Groups. Purchasing groups that obtain insurance from an unauthorized or authorized surplus lines insurer will use an Idaho-licensed Broker. The Broker is responsible to collect and submit all taxes and fees as prescribed by this chapter. ( )

016. REPORTING TAXES AND STAMPING FEES.
Brokers are to report premium taxes and stamping fees in increments of not less than one year. A Broker who collects quarterly or monthly payments of premiums from the insured will provide reports of the premium tax and stamping fee in the initial submission or renewal for a full year. ( )

017. PLACEMENT AND COMMISSIONS.

01. Basic Requirement. All surplus line business is to be placed through a licensed Broker. Each producer of surplus line business will hold an Idaho resident or non-resident producer license. ( )

02. Idaho Producer. When a producer requests placement by a licensed Broker, the commission received and paid will be based on the mutual written agreement of the parties. ( )

018. SUBMISSION TIME PERIODS.
All affidavits, submissions, certificates, endorsements and other documents for insurance written for Open Lines for Export and Other Than Open Lines for Export are to be received by the delegated contractor within thirty (30) days of receipt by the broker of the certificate, endorsement or other policy document. If the complete submission cannot be made within this time period, the information with submission form and affidavit, if applicable, will be forwarded. The Broker is responsible for meeting this requirement. ( )

019. OPEN LINES FOR EXPORT.
Pursuant to Section 41-1216, the Director will publish a list of approved classes of insurance coverage or risks. If a risk does not appear on this list, then the Broker will file the normal submission forms and documents and execute the broker's affidavit. ( )

020. BROKER RECORDS.
A full and true record of each surplus line coverage procured by each Broker is to be maintained by the Broker. Reports of all documents processed by the delegated contractor will be provided on a monthly basis to the Broker. These reports, in addition to the broker's copy of policies and endorsements, are to be kept for a period of five (5) years and are subject to examination by the Director. ( )

021. APPROVED LIST OF INSURERS.
Pursuant to Section 41-1217, Idaho Code, the Director compiles or approves a list of unauthorized insurers, whether foreign or alien, eligible to write surplus line business in Idaho. Brokers may only place surplus line business with companies on the current list. The delegated contractor will inform Brokers of additions and changes to the list.
( )

022. -- 999. (RESERVED)

18.07.01 – RULES PERTAINING TO ACQUISITIONS OF CONTROL, INSURANCE HOLDING COMPANY SYSTEMS AND MUTUAL INSURANCE HOLDING COMPANIES

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 38, Sections 41-211 and 41-3817, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.01, "Rules Pertaining to Acquisitions of Control, Insurance Holding Company Systems and Mutual Insurance Holding Companies." ( )

02. Scope. These rules set forth procedural requirements necessary to administer the Idaho Acquisitions of Control and Insurance Holding Company Systems Regulatory Act, Title 41, Chapter 38, Idaho Code, including those provisions related to mutual insurance holding companies under Section 41-3824, Idaho Code, which is a distinct form of insurance holding company system. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the definitions set forth in Chapter 38, Title 41, Idaho Code, the following definitions apply: ( )

01. Affiliated Person. ( )

a. Any person directly or indirectly owning, controlling, or holding with power to vote, five percent (5%) or more of the outstanding voting securities of such other person; or ( )

b. Any person, five percent (5%) or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person; or ( )

c. Any person directly or indirectly controlling, controlled by, or under common control with, such other person; or ( )

d. Any officer, director, partner, copartner, or employee of such other person. ( )

02. Domestic Mutual Insurance Company. A mutual insurer as defined in Section 41-302, Idaho Code, that is incorporated under Idaho law. ( )

03. Executive Officer. 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. ( )

04. Interested Person. Interested person of another person means: ( )

a. An affiliated person of such person or company; or ( )

b. A member of the immediate family of any natural person who is an affiliated person of such company; or ( )

c. Any person, partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as acted as legal counsel for such company; or ( )

d. Any natural person whom the Director by order has determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company. ( )

05. Intermediate Holding Company. A holding company subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company. ( )

06. Limited Application. An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, one hundred percent (100%) of the stock of its insurance subsidiaries. ( )

07. Member of the Immediate Family. Any parent, spouse of a parent, child, spouse of a child, spouse, brother or sister, and includes step and adoptive relationships. ( )

08. Mutual Insurance Holding Company or MHC. A holding company formed pursuant to Section 41-3824, Idaho Code, and this chapter. ( )

09. Plan of Reorganization. A plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company. ( )

10. Standard Application. An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties. ( )

12. Stock. Any security evidencing an equity interest in the issuing entity. ( )

13. Stock Offering. Any proposed sale, exchange, transfer or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. "Stock offering" does not mean: ( )

a. An offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights; or ( )

b. A transfer of stock between any of the following: ( )

i. A mutual insurance holding company; or ( )

ii. An insurance company subsidiary of a mutual insurance holding company; or ( )

iii. An intermediate holding company subsidiary of a mutual insurance holding company; or ( )

iv. An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company. ( )

14. Ultimate Controlling Person. That person who is not controlled by any other person. ( )

011. FORMS -- GENERAL REQUIREMENTS.

01. Forms Intended to Be Guides. Forms A, B, C, D, E, and F included on the Department's website are guides in the preparation of statements prescribed by Title 41, Chapter 38, Idaho Code, and not intended as fillable blank forms. Statements need to contain the numbers and captions of all items. The text of the items may be omitted if the answers indicate clearly their scope and coverage. All instructions are to be omitted. If any item is inapplicable or the answer is in the negative, an appropriate statement should be made unless otherwise provided. ( )

02. Filings. Each statement, including exhibits and all other papers and documents are to be filed with the Director electronically with one (1) hard copy filed by personal delivery or mail. At least one (1) of the copies is to be signed in the manner noted on the form. Unsigned copies will be conformed. If a signature is affixed pursuant to a power of attorney or similar authority, a copy of the power of attorney or other authority should be filed with the statement. ( )

03. Format. Statements should be prepared electronically, easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories should be clearly distinguishable on photocopies. The English language is to be used and monetary values stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, a translation into the English language is to be included and monetary value shown in a foreign currency be converted into United States currency. ( )

04. Hearing. If an applicant requests a hearing on a consolidated basis under Section 41-3806(3), Idaho Code, in addition to filing the Form A with the Director, the applicant will electronically file a copy of Form A with the NAIC (National Association of Insurance Commissioners). ( )

012. FORMS -- INCORPORATION BY REFERENCE, SUMMARIES AND OMISSIONS.

01. Incorporation by Reference. Information prescribed by any item of a Form needed by law or this rule 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 other document may be incorporated by reference in answer or partial answer to any item if the document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits.Documents filed with the Director within the three (3) years prior to the statement need not be attached as exhibits. References to information contained in exhibits or in documents already on file need to clearly identify the material and specifically indicate that the material is incorporated by reference. Matter cannot be incorporated by reference when incorporation would make the statement incomplete, unclear or confusing. ( )

02. Summaries or Outlines. A brief statement need be made as to the pertinent provisions of a document when an item requires a summary or outline of a document. The summary or outline may incorporate by reference parts of any exhibit or document filed with the Director within the three (3) prior years and qualified by this reference. If two (2) or more documents need to be filed as exhibits are substantially identical in all material respects except as to parties, the dates of execution, or other details, one (1) of the documents should be filed with a schedule identifying the omitted documents and indicating any material details in which the omitted documents differ from the filed documents. ( )

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

If any necessary information, document or report cannot be furnished at the time it needs to be filed, a person needs to: identify the information, document or report in question; **s**tate why the filing at the time prescribed is impractical; and request an extension of time for filing to a specified date. The request for extension is deemed granted unless the Director issues an order denying the request within twenty-eight (28) days of receipt. ( )

014. FORMS -- ADDITIONAL INFORMATION AND EXHIBITS.

In addition to the information expressly prescribed to be included on necessary Forms, the Director may request additional information necessary for clarification. The filer may file exhibits in addition to those expressly necessary by the statement, clearly indicating clearly the referred subject matter. Changes to content in necessary Forms include the following phrase on the top of the cover page "Change No. [insert number] to" and date of the change. ( )

015. SUBSIDIARIES OF DOMESTIC INSURERS.

The authority to invest in subsidiaries under Section 41-3803, Idaho Code, is in addition to authority to invest in subsidiaries contained in any other provision of Title 41, Idaho Code. ( )

016. ACQUISITION OF CONTROL -- STATEMENT FILING.

A person obligated to file a statement pursuant to Section 41-3804, Idaho Code, needs to furnish the prescribed information on Form A, found on the Department's website. The person will also furnish the prescribed information on Form E, also found on the Department's website. ( )

017. AMENDMENTS TO FORM A.

The applicant needs to promptly advise the Director of any changes in the Form A information arising after the date when the information was furnished, but prior to the Director's disposition of the application. ( )

018. ACQUISITION OF SECTION 41-3804(1)(D) INSURERS.

01. Name of the Domestic Insurer. If the person being acquired is deemed to be a "domestic insurer" under Section 41-3804(1)(d), Idaho Code, the name of the domestic insurer on the cover page is stated as: "ABC Insurance Company, a subsidiary of XYZ Holding Company." ( )

02. References to Insurer. Where a Section 41-3804(1)(d) insurer is acquired, references to "the insurer" contained in Form A refers to both the domestic subsidiary insurer and the acquired person. ( )

019. PRE-ACQUISITION NOTIFICATION.

01. Pre-Acquisition Notification. If a domestic insurer, including any controlling person, is proposing a merger or acquisition pursuant to Section 41-3808(1)(a), Idaho Code, they need to file a Form E pre-acquisition notification form. If a licensed non-domiciliary insurer is proposing a merger or acquisition pursuant to Section 41-3808, Idaho Code, they need to file a Form E pre-acquisition notification form, unless the filing is exempted under Section 41-3808(2), Idaho Code. ( )

02. Expert Opinion. The director may request the filing of an expert opinion regarding the competitive impact of the proposed acquisition. ( )

020. ANNUAL REGISTRATION OF INSURERS -- STATEMENT FILING.
An insurer obligated to file a statement pursuant to Section 41-3809, Idaho Code, will furnish prescribed information on Form B, found on the Department's website. ( )

021. SUMMARY OF REGISTRATION -- STATEMENT FILING.
An insurer obligated to file an annual registration statement pursuant to section 41-3809, Idaho Code, is also obligated to furnish information prescribed on Form C, found on the Department's website. ( )

022. AMENDMENTS TO FORM B.

01. Amendment to Form B. Amendments to Form B will be filed within fifteen (15) days after the end of any month in which there is a material change to the information provided in the annual registration statement. ( )

02. Form B Format. Amendments are filed in the Form B format with only amended items reported. Each amendment will include at the top of the cover page "Amendment No. [insert number] to Form B for [insert year]" and indicate the date of the change, not the date of the original filings. ( )

023. ALTERNATIVE AND CONSOLIDATED REGISTRATIONS.

01. Filing on Behalf of Affiliated Insurers. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers obligated to register. A registration statement may include information regarding any insurer in the holding system, even if the insurer is not authorized to do business in this state. An authorized insurer may, in lieu of Form B, file a copy of the registration statement or similar report prescribed to be filed in its state of domicile, provided: ( )

a. The statement or report contains substantially similar information prescribed on Form B; and ( )

b. The filing insurer is the principal insurance company in the insurance holding company system. ( )

02. Statement That Filing Insurer Is the Principal Insurer. An insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, will provide a statement of facts substantiating the filing insurer's claim that it is the principal insurer in the insurance holding system. ( )

03. Unauthorized Insurer. With the Director's prior approval, an unauthorized insurer may follow any procedures under Subsection 023.01 of this rule. ( )

04. Consolidated Registration Statements. An insurer may follow the provisions of Section 41-3809(8), or 41-3809(9), Idaho Code, without the Director's prior approval. The Director reserves the right to obligate individual filings if such are necessary for clarity, ease of administration or the public good. ( )

024. DISCLAIMERS AND TERMINATION OF REGISTRATION.

01. Information Requisite. A disclaimer of affiliation or a request for termination of registration, on the basis that a person does not, or will not, upon the taking of some proposed action, control another person

(hereinafter referred to as the "subject") will contain the following information: ( )

a. The number of authorized, issued and outstanding voting securities of the subject; ( )

b. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly; ( )

c. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person: ( )

d. A statement explaining why such person should not be considered to control the subject. ( )

02. Request Deemed Granted. A request for termination of registration is deemed granted unless the Director notifies the filer otherwise within thirty (30) days after the request is received. ( )

025. TRANSACTIONS SUBJECT TO PRIOR NOTICE - NOTICE FILING.

01. Form D. An insurer prescribed to give notice of a proposed transaction pursuant to section 41-3810, Idaho Code, will furnish the needed information in Subsection 025.02 on Form D. ( )

02. Agreements. Agreements for cost sharing services and management services are at a minimum and as applicable: ( )

a. Identify the person providing services and the nature of such services; ( )

b. Set forth the methods to allocate costs; ( )

c. Prescribe timely settlement, at least on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual; ( )

d. Bar advancement of funds by the insurer to the affiliate except to pay for services specified in the agreement; ( )

e. 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; ( )

f. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement; ( )

g. 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; ( )

h. 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; ( )

i. Include standards for termination of the agreement with and without cause; ( )

j. 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; ( )

k. Specify that, if the insurer is placed in receivership or seized by the Director under Title 41, Chapter 33, Idaho Code: ( )

i. All of the rights of the insurer under the agreement extend to the Director; and ( )

ii. All books and records will immediately be made available to the Director, and will be turned over to the Director immediately upon the Director's request; ( )

l. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Title 41, Chapter 33, Idaho Code; and ( )

m. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Director under Title 41, Chapter 33, Idaho Code, and will make them available to the Director, for so long as the affiliate continues to receive timely payment for services rendered. ( )

026. ENTERPRISE RISK REPORT.
The ultimate controlling person of an insurer needs to file an enterprise risk report pursuant to Section 41-3809(12), Idaho Code, will furnish the prescribed information on Form F, found on the Department's website. ( )

027. EXTRAORDINARY DIVIDENDS AND OTHER DISTRIBUTIONS.

01. Request for Approval. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders will include the following: ( )

a. The amount of the proposed dividend; ( )

b. The date established for payment of the dividend; ( )

c. A statement whether the dividend is in cash or other property and, if in property, a description thereof, its cost, its fair market value, and an explanation of the valuation basis; ( )

d. The calculations determining that the proposed dividend is extraordinary. The work paper needs to include the following information: ( )

i. 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 (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year; ( )

ii. Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding; ( )

iii. If the insurer is a life insurer, the net gain from operations for the twelve (12) month period ending the 31st day of December next preceding; and ( )

iv. If the insurer is not a life insurer, the net income less net realized capital gains for the twelve (12) month period ending the 31st day of December next preceding. ( )

e. 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 ( )

f. A statement of the effect of the proposed dividend on 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. ( )

02. Other Dividends. Subject to Section 41-3812, Idaho Code, each registered insurer reports to the Director all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information prescribed by Subsections 027.01.d. ( )

028. ADEQUACY OF SURPLUS.
Factors in Section 41-3811, Idaho Code, are not an exhaustive list and no single factor is controlling. The Director

will consider the net effect of all factors and other factors bearing on the insurer's financial condition. Comparing other insurers' surplus, the Director will consider the extent to which each factor varies among companies. The Director's determination of the quality and liquidity of investments in subsidiaries will include a consideration of the individual subsidiary and may discount or disallow its valuation to the extent individual investments warrant. ( )

029. -- 050. (RESERVED)

051. MUTUAL HOLDING COMPANY APPLICATION - CONTENT - PROCESS.

01. Designation of Application as Limited or Standard. An application a limited application or a standard application. Filing a limited application does not preclude the later filing of an application for approval of an initial sale of stock as provided in this chapter. ( )

02. Information to Be Contained in Application. The application is filed in duplicate and will includes: ( )

a. Designation as limited or standard; ( )

b. A Plan of Reorganization ("Plan"); ( )

c. A plan for policyholder approval in accordance with the applicant's articles of incorporation and bylaws, with at least twenty (20) days notice to the policyholders of any such plan; ( )

d. A copy of the MHC's proposed articles of incorporation and bylaws specifying all membership rights; ( )

e. The names, addresses and occupations of all corporate officers and members of the MHC's board of directors; ( )

f. Information sufficient to demonstrate that the applicant's financial condition will not be diminished upon reorganization; ( )

g. A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary; ( )

h. A Form A filing; ( )

i. An application index; and ( )

j. Any other information requested by the Director. ( )

052. NOTICE OF HEARING.

01. Scheduling. A hearing will be held after receipt and review by the Director of the application. ( )

02. Evidence to Be Presented at Hearing. The applicant will provide evidence that the application is complete, complies with Idaho law, and the requirements for reorganization have been fulfilled. ( )

03. Notice of Hearing. The Department will provide notice of the hearing to known interested parties at least twenty (20) days prior to the hearing. ( )

053. PLAN OF REORGANIZATION.

01. Plan of Reorganization. The plan of reorganization or **"**Plan**"** needs to preserve property and protect policyholders' interest, be fair and equitable to policyholders, and not diminish the applicant's financial

condition. ( )

02. Limited Application. A limited application plan of reorganization needs to include: ( )

a. Establishing an MHC with at least one (1) stock insurance company subsidiary or one (1) intermediary stock holding company with a stock insurance company subsidiary, the share of which is held exclusively by the mutual insurance holding company; ( )

b. Protection of existing policyholders' interests; ( )

c. Providing existing and future policyholder membership in the MHC; ( )

d. The number of policyholder members of the board of directors of the MHC; ( )

e. Demonstrating that, if there are proceedings under Title 41, Chapter 33, Idaho Code, involving a stock insurance company subsidiary of the MHC, the assets of the MHC will be available to satisfy the policyholder obligations of the stock insurance company; ( )

f. How any accumulation or prospective accumulation of earnings by the MHC in excess of that determined by the board of directors to be necessary will invoke to the exclusive benefit of the MHC's member policyholders; ( )

g. The nature and content of the annual report and financial statement sent to each member; and ( )

h. Other matters the applicant deems appropriate. ( )

03. Standard Application. A standard application Plan includes: ( )

a. Establishing an MHC with at least one (1) stock insurance company subsidiary or one (1) wholly-owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which are held exclusively by the wholly- owned intermediate holding company; ( )

b. Protection of existing policyholders' interests; ( )

c. Providing existing and future policyholder membership in the MHC; ( )

d. The number of policyholder members of the board of directors of the MHC mutual; ( )

e. Demonstrating that, if there are proceedings under Title 41, Chapter 33, Idaho Code, involving a stock insurance company subsidiary of the MHC, the assets of the MHC will be available to satisfy the policyholder obligations of the stock insurance company; ( )

f. How any accumulation or prospective accumulation of earnings by the MHC excess of that determined by the MHC's board of directors to be necessary will inure to the exclusive benefit of the MHC's member policyholders; ( )

g. The nature and content of the annual report and financial statement sent to each member; and ( )

h. The plan for a stock offering in accordance with this rule; and ( )

i. Other matters the applicant deems appropriate. ( )

054. DUTIES OF THE DIRECTOR.

01. Jurisdiction. The Director will retain jurisdiction over the MHC and any intermediate holding

company subsidiaries with stock insurance company subsidiaries. ( )

02. Approval or Denial of Application. The Director will, by order, approve, conditionally approve, or deny an application. ( )

a. Modifications. The Director may prescribe modifications of the proposed plan of reorganization. Prescribed modifications are accepted by filing amendments to the proposed plan of reorganization with the Director within thirty (30) days after the Director's order is issued. Failure to file the prescribed amendments will result in denial of the plan. ( )

b. Expiration. An approval or conditional approval of a Plan expires if the reorganization is not completed within one hundred eighty (180) days unless such time period is extended by the Director upon a showing of good cause. ( )

c. Revocation of approval. The Director may revoke approval or conditional approval of an applicant's plan of reorganization in the event the Director finds the applicant has failed to comply with the plan of reorganization. The Director may compel completion of a plan of reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance. The Director retains jurisdiction over the applicant until a plan of reorganization has been completed. ( )

d. Notice of completion. Upon completion of all elements of a plan of reorganization, the applicant provides a notice of completion to the Director. ( )

055. REGULATION - COMPLIANCE.

01. Wavier of Compliance. No regulatory standards are waived during the pendency of a Plan application. ( )

02. Merger or Acquisition. MHC mergers and acquisitions are subject to approval by the Director. The acquisition of more than fifty percent (50%) of a stock insurance company by an MHC is subject to the filing of a plan describing the insurer's policyholders' membership interests in the MHC. ( )

03. Annual Financial Statement. An MHC Each will annually file a financial statement by June 1 including: ( )

a. An income statement; ( )

b. A balance sheet; ( )

c. A cash flow statement; ( )

d. The status of any closed block formed as a result of the Plan; ( )

e. An asset investment plan; and ( )

f. A statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the MHC. ( )

04. Subsidiary Investment Obligations. At least fifty percent (50%) of the generally accepted accounting practices (GAAP) basis net worth of an MHC will be invested in insurance company subsidiaries. ( )

05. Distributions to Policyholders. Payment of policy credits, dividends or other distributions to policyholder members of a MHC needs to be fair and equitable, and are subject to the Director's approval and the public hearing process under Chapter 38, Title 41, Idaho Code. ( )

056. REORGANIZATION OF MUTUAL INSURER WITH MUTUAL INSURANCE HOLDING COMPANY.
Domestic mutual insurance companies may merge their policyholders' interests into an MHC by filing with the Director a joint application with the MHC that complies with the provisions of this chapter. This provision also applies to foreign mutual insurance companies or a foreign health service corporation, which, if a domestic corporation, would be organized under Title 41, Chapter 28, Idaho Code. ( )

057. MERGERS OF MUTUAL INSURANCE HOLDING COMPANIES.
Two (2) or more MHCs may merge by filing with the Director a plan of merger in compliance with this chapter. ( )

058. STOCK OFFERINGS.

01. Prior Approval. A stock offering by a MHC or any direct or indirect insurance company subsidiary or intermediate holding company subsidiary of a MHC is subject to the prior approval of the Director through the application and hearing process described in this section. ( )

02. Application for Stock Offering Contents. ( )

a. A description of the stock intended to be offered by the applicant and all shareholder rights; ( )

b. The total number of shares authorized to be issued, the estimated number requested to offer, and the intended date or range of dates for the offer; ( )

c. A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined; ( )

d. The name or names of any underwriter, syndicate member or placement agent involved and, if known, the names of each entity, person, or group of persons to whom the stock offering is to be made who will control five percent (5%) of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management will be provided with the name of each member of the board of directors of the offeror. Copies of Securities and Exchange Commission filings disclosing intended acquisitions of the stock will be included; ( )

e. A description of stock subscription rights afforded to members of the MHC in conjunction with the stock offering; ( )

f. A detailed description of all expenses to be incurred in the stock offering; ( )

g. How funds raised by the stock offering will be used; and ( )

h. Any other information requested by the Director. ( )

03. Prescribed Provisions. The stock offering plan needs to include the following provisions: ( )

a. Officers, directors, and insiders of the MHC and its direct or indirect subsidiaries and affiliates are restricted from purchasing or owning shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors and insiders, for at least six (6) months following the first public offering date and regularly trading of the stock. Officers, directors and insiders are not barred from exercising subscription rights accorded to members of the MHC, except that, pursuant to those rights, the officers, directors, and insiders of the MHC and its direct or indirect subsidiaries and affiliates cannot purchase or own, in the aggregate, more than five percent (5%) of the stock offering for at least six (6) months following the first date of the public offering and regular trading of the stock; ( )

b. A majority of the members of the board of directors of the MHC cannot be an interested persons of the MHC or of an affiliated person of the MHC. The Director may waive this requirement upon a showing of good cause; ( )

c. The MHC will to adopt articles of incorporation barring any waiver of dividends from stock subsidiaries except under conditions specified in the articles and after approval of the waiver by the board of directors of the MHC and the Director; ( )

d. After the initial stock offering by a direct or indirect insurance company or intermediate insurance company subsidiary of a MHC, the boards of directors of each such insurance company or intermediate holding company will include at least three (3) directors who are not interested persons of the MHC; and ( )

e. The board of directors of the corporation offering stock need to establish, a pricing committee consisting exclusively of directors who are interested persons. The committee's responsibility is to evaluate and approve the price of any stock offering. ( )

04. More Than One Class of Stock. A direct or indirect n insurance company or intermediate insurance holding company subsidiary of an MHC may issue more than one (1) class of stock. However, at all times a majority of the voting stock is will be held by the MHC or its subsidiary and, no class of common stock may possess greater dividend or other rights than the class held by the MHC or its subsidiary. ( )

05. Experts. The Director may hire experts to assist in the review of the application, at the applicant's expense. ( )

06. Public Hearing. A public hearing may be held regarding any stock offering application. A stock offering including an initial offering of stock is expressly subject to a public hearing. The applicant will provide Director-approved notice of the hearing to MHC members at least twenty (20) days prior to the hearing. ( )

07. Approval. The stock offering plan may be approved if: ( )

a. The method for establishing the stock offering price is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions; and ( )

b. The offering will not unfairly impact the interests of MHC members. ( )

08. Concurrent Filing with SEC. The filing of a registration statement with the Securities and Exchange Commission prior to or concurrently with notice to the MHC members is not banned. ( )

09. Subsequent Offerings of Publicly Traded Stock. ( )

a. Notwithstanding the provisions of Section 013 of this chapter, stock offerings other than an initial stock offering, through which stock offered is regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the Director, or designated on the national association of securities dealers automated quotations - national market system (NASDAQ), is subject to the following procedure: If an MHC or direct or indirect insurance company or intermediate insurance company subsidiary thereof intends to make a stock offering governed by the provisions of this section, the entity will provide notice to the Director, not less than thirty (30) days prior to the offering regarding: ( )

i. The total number of shares intended to be offered; ( )

ii. The intended date of sale; ( )

iii. Evidence the stock is regularly traded on one of the public exchanges noted above; and ( )

iv. A record of the trading pace and trading volume of the stock during the prior fifty-two (52) weeks. ( )

b. The Director may object to the offering within thirty (30) days following receipt of the notice. Upon an objection, the procedures Subsection 059.02 of this chapter will be followed to determine approval. ( )

10. Expiration of Approval. Approval of a stock offering under Subsection 059.06, 059.07, or 059.08 expires ninety (90) days following the date of the approval, except as provided by the Director's order. ( )

11. Representation of Director's Approval. A prospectus, information, sales material or sales presentation by the applicant, or a representative, agent or affiliate of the applicant, will not contain a representation that the Director's approval constitutes an endorsement of the price, price range, or any other information relating to the stock. ( )

059. BANNED MHC - PRACTICES.

01. Borrowing Funds. Borrowing funds from the MHC, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering. ( )

02. Payment of Commissions. Payment of commissions, **"**special fees**"** or any other special payments or extraordinary compensation to officers, directors, interested persons and affiliates, for arranging, promoting, aiding or assisting in reorganization or for arranging promoting, aiding assisting or participating in the structuring and placement of a stock offering. ( )

03. Avoidance of Provisions of Chapter. Transferring legal or beneficial ownership of stock to another person not in compliance with of this chapter. ( )

060. REGULATION OF HOLDING COMPANY SYSTEM.
All material transactions between subsidiaries and affiliates of the MHC need to be approved by a majority of the directors of the MHC as fair and reasonable, on terms and conditions not less favorable than those available from unaffiliated third parties. ( )

061. REPORTING OF STOCK OWNERSHIP AND TRANSACTIONS.

01. Acquisition of Ownership Interest. Any director or officer of an MHC or its direct or indirect subsidiaries or affiliates, who directly or indirectly acquires the beneficial ownership of any security issued by any member of the MHC system will, within fifteen (15) days following the transaction, file a statement of the transaction in a format prescribed by the Director. ( )

02. Filing of SEC Forms. An MHC and its direct or indirect subsidiaries and affiliates, will file with the Director copies of Form 3, Form 4 and Schedule 13D, or any equivalent filings, made under the Securities and Exchange Act of 1934, as amended, within fifteen (15) days of receipt thereof. ( )

062. -- 999. (RESERVED)

18.07.02 – RESERVE LIABILITIES AND MINIMUM VALUATIONS FOR ANNUITIES AND PURE ENDOWMENT CONTRACTS

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 6, Sections 41-211 and 41-612, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.02, "Reserve Liabilities and Minimum Valuations for Annuities and Pure Endowment Contracts." ( )

02. Scope. To determine minimum standard valuation for annuity and pure endowment contracts. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. 1983 Table 'a'. The mortality table developed by the Society of Actuaries Committee for Individual Annuity Valuation in 1981 and in June 1982 by the National Association of Insurance Commissioners. ( )

02. 1983 GAM Table. The 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. ( )

03. 1994 GAR Table. The mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume 47 of the Transactions of Society of Actuaries 1995. ( )

04. 2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table. 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. ( )

05. 2012 Individual Annuity Reserving (2012 IAR) Table. The generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n} derived from a combination of the 2012 IAM Period table and Projection Scale G2, using the methodology stated in Section 014. ( )

06. Annuity 2000 Mortality Table. The mortality table developed by the Society of Actuaries Committee on Life Insurance Research. ( )

07. Generational Mortality Table. 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. ( )

08. Period Table. A a table of mortality rates applicable to a given calendar year (the Period). ( )

09. Projection Scale G2 (Scale G2). 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. ( )

011. INDIVIDUAL ANNUITY OR PURE ENDOWMENT CONTRACTS.

01. Individual Annuity Mortality Table. Except as provided in Subsections 011.02 and 011.03, of this rule, the 1983 Table 'a' is recognized and approved as an individual annuity mortality table for valuation and, at the company's option, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1982. ( )

02. Minimum Standard for Valuation. Except as provided in Subsection 011.03 of this rule, either the 1983 Table 'a' or the Annuity 2000 Mortality Table is used for determining the minimum standard of valuation

for any individual annuity or pure endowment contract issued on or after January 1, 1987. ( )

03. The Annuity 2000 Mortality Table. Except as provided in Subsection 011.04 of this rule, the Annuity 2000 Mortality Table is used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after March 29, 2012. ( )

04. The 2012 IAR Mortality Table. Except as provided in Subsection 011.05 of this rule, the 2012 IAR Mortality Table is used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2015. ( )

05. The 1983 Table 'a.' 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 March 29, 2012, solely when the contract is based on life contingencies and issued to fund periodic benefits arising from: ( )

a. Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions; ( )

b. Settlements involving similar actions such as workers' compensation claims; or ( )

c. Settlements of long-term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments. ( )

012. GROUP ANNUITY OR PURE ENDOWMENT CONTRACTS.

01. Group Annuity Mortality Tables. Except as provided in Subsections 012.02 and 012.03 of this rule, 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 (1) of these tables may be used for purposes of valuation for any annuity or pure endowment purchased on or after July 1, 1982, under a group annuity or pure endowment contract. ( )

02. Minimum Standard of Valuation. Except as provided in Subsection 012.03 of this rule, either the 1983 GAM Table or the 1994 GAR Table is used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987, under a group annuity or pure endowment contract. ( )

03 1994 GAR Table. The 1994 GAR Table will be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after the effective date of Subsection 012.03 under a group annuity or pure endowment contract. ( )

013. FORMULA.
In using the 1994 GAR table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1\text{-}AAx)^n$$

Where the q_x^{1994} and AA_xs are specific in the 1994 GAR table. ( )

014. APPLICATION OF THE 2012 IAR MORTALITY TABLE.

01. Mortality Rate Formula. In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows: ( )

a. $q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$ ( )

b. The resulting q_x^{2012+n} is to be rounded to three (3) decimal places per one thousand (1,000), e.g., 0.741 deaths per one thousand (1,000). The rounding is to occur according to the formula above, starting at the 2012

period table rate. ( )

02. Mortality Rate Formula Example. For a male age 30, q_x^{2012}=0.741: ( )

a. q_x^{2013}=0.741 * (1 - 0.010) ^ 1 = 0.73359, which is rounded to 0.734. ( )

b. q_x^{2014}=0.741 * (1 - 0.010) ^ 2 = 0.7262541, which is rounded to 0.726. ( )

c. 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}. ( )

015. -- 999. (RESERVED)

18.07.03 – VALUATION OF LIFE INSURANCE POLICIES INCLUDING THE USE OF SELECT MORTALITY FACTORS

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 6, Sections 41-211 and 41-612, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.03, "Valuation of Life Insurance Policies Including the Use of Select Mortality Factors." ( )

02. Purpose. To provide: ( )

a. Tables of select mortality factors and rules for their use; ( )

b. Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and ( )

c. Rules concerning a minimum standard for the valuation of plans with secondary guarantees. ( )

03. Method. The method for calculating basic reserves defined in this chapter will constitute the commissioners' reserve valuation method for policies to which this chapter is applicable. ( )

04. Applicability. This chapter applies to all life insurance policies, with or without nonforfeiture values, issued on or after March 30, 2001,subject to the following exceptions and conditions. ( )

a. Exceptions: ( )

i. This chapter does not apply to any individual life insurance policy issued on or after March 30, 2001, 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 March 30, 2001, that guarantees the premium rates of the new policy. This chapter also does 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. ( )

ii. This chapter does not apply to a universal life policy that meets all the following requirements: ( )

(1) Secondary guarantee period, if any, is five (5) years or less; ( )

(2) 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 Subsection 010.06 and the applicable valuation interest rate; and ( )

(3) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period. ( )

iii. This chapter does not apply to a variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts. ( )

iv. This chapter does not apply to a variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts. ( )

v. This chapter does not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums needed in order to continue coverage in force for a period in excess of one (1) year. ( )

b. Conditions: ( )

i. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, is in accordance with the

provisions of Section 012. ( )

ii. 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 will be in accordance with the provisions of Section 013. ( )

002. INCORPORATION BY REFERENCE.
The tables of select mortality factors are incorporated by reference into IDAPA 18.07.03, "Valuation of Life Insurance Policies Including the Introduction and Use of the New Select Mortality Factors" that are the bases to which the respective percentage of Subsections 011.01.b., 011.02.b., and 011.02.c. are applied. ( )

01. Types of Tables. The six (6) tables of select mortality factors incorporated by reference include: ( )

a. Male aggregate; ( )

b. Male nonsmoker; ( )

c. Male smoker; ( )

d. Female aggregate; ( )

e. Female nonsmoker; and ( )

f. Female smoker. ( )

02. Age Basis. These tables apply to both age last birthday and age nearest birthday mortality tables. ( )

03. Computation for Sex-Blended 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 as referenced in Section 004, plus twenty percent (20%) of the appropriate female table, as referenced in Section 004. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Basic Reserves. Reserves calculated in accordance with Section 41-612(5), Idaho Code. ( )

02. Contract Segmentation Method. 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 this chapter, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the effective date of this chapter or promulgated by rule by the Director for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves set forth in Subsection 011.02. The length of a particular contract segment will 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:

- Formulas -

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

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 (1%) in any policy year, at the company's option, but R_t cannot be less than one (1);

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 Paragraph 011.02.b. if Paragraph 011.02.c. is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t is presumed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t is presumed to be 0. ( )

03. Deficiency Reserves. Excess, if greater than zero (0), of ( )

a. Minimum reserves calculated in accordance with Section 41-612(10), Idaho Code, over ( )

b. Basic reserves. ( )

04. Guaranteed Gross Premiums. Premiums under a policy of life insurance that are guaranteed and determined at issue. ( )

05. Maximum Valuation Interest Rates. Interest rates defined in Section 41-612(4b), Idaho Code (Computation of Minimum Standard by Calendar Year of Issue) used in determining the minimum standard for the valuation of life insurance policies. ( )

06. 1980 CSO Valuation Tables. Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten (10) year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983. ( )

07. Scheduled Gross Premium. 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 Paragraph 013.01.c., if any, or else the minimum premium described in Paragraph 013.01.d. ( )

08. Segmented Reserves. ( )

a. 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: ( )

i. The present value of the death benefits within the segment, plus ( )

ii. The present value of any unusual guaranteed cash value (see Subsection 012.04) occurring at the end of the segment, less ( )

iii. Any unusual guaranteed cash value occurring at the start of the segment, plus ( )

iv. For the first segment only, the excess of the Item one (1) over Item two (2), as follows: ( )

(1) 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 (1) 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 will not exceed the net level annual premium on the nineteen (19) year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one (1) year higher than the age at issue of the policy. ( )

(2) A net one (1) year term premium for the benefits provided for in the first policy year. ( )

b. The length of each segment is determined by the "contract segmentation method," as defined in this chapter. ( )

c. The interest rates used in the present value calculations for any policy cannot exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy. ( )

d. For both basic reserves and deficiency reserves computed by the segmented method, present values will include future benefits and net premiums in the current segment and in all subsequent segments. ( )

09. Tabular Cost of Insurance. The net single premium at the beginning of a policy year for one (1) year term insurance in the amount of the guaranteed death benefit in that policy year. ( )

10. Ten Year Select Factors. The select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law. ( )

11. Unitary Reserves. ( )

a. The present value of all future guaranteed benefits less the present value of all future modified net premiums, where: ( )

i. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and ( )

ii. 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 one (1) over Item two (2), as follows: ( )

(1) 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 (1) 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 will not exceed the net level annual premium on the nineteen (19) year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one (1) year higher than the age at issue of the policy. ( )

(2) A net one (1) year term premium for the benefits provided for in the first policy year. ( )

b. The interest rates used in the present value calculations for any policy will 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. ( )

12. Universal Life Insurance Policy. 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. ( )

011. GENERAL CALCULATION REQUIREMENTS FOR BASIC RESERVES AND PREMIUM DEFICIENCY RESERVES.

01. Basic Reserves. At the company's election for any one (1) 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 chapter and promulgated by rule by the Director for this purpose). If select mortality factors are elected, they may be: ( )

a. The ten (10) year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; ( )

b. The select mortality factors in the tables as referenced in Section 004; or ( )

c. Any other table of select mortality factors adopted by the NAIC after March 30, 2001, promulgated by rule for the purpose of calculating basic reserves. ( )

02. Deficiency Reserves. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero (0), 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 company's election 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 March 30, 2001, and promulgated by rule). If select mortality factors are elected, they may be one (1) of the following: ( )

a. The ten (10) year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; ( )

b. The select mortality factors in the tables as referenced in Section 004; ( )

c. For durations in the first segment, X percent of the select mortality factors in the tables as referenced in Section 004, subject to the following: ( )

i. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience; ( )

ii. X is such that, when using the valuation interest rate used for basic reserves, Item one (1) is greater

than or equal to Item two (2); ( )

(1) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X; ( )

(2) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date; ( )

iii. 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; ( )

iv. The appointed actuary will increase X at any valuation date where it is necessary to continue to meet all the requirements of Paragraph 011.02.c.; ( )

v. The appointed actuary may decrease X at any valuation date as long as X continues to meet all the requirements of Paragraph 011.02.c.; and ( )

vi. The appointed actuary will specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums. ( )

vii. If X is less than one hundred percent (100%) at any duration for any policy, the following requirements are to be met: ( )

(1) The appointed actuary will annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of the Actuarial and Memorandum Rule, IDAPA 18.07.10, Section 022, "Statement of Actuarial Opinion Based on an Asset Adequacy Analysis"; ( )

(2) The appointed actuary will disclose, in the Regulatory Asset Adequacy Issues Summary, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one (1) or more interim periods; and ( )

(3) The appointed actuary will annually opine for all policies subject to this chapter as to whether the mortality rates resulting from the application of X meet the requirements of Paragraph 011.02.c. This opinion will 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 will reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience. ( )

d. Any other table of select mortality factors adopted by the NAIC after March 30, 2001, and promulgated by rule for the purpose of calculating deficiency reserves. ( )

03. Applicability. Subsection 011.03 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 (10) 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. ( )

04. Gross Premiums. 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. ( )

05. Changes in Guarantees. 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 (1) year after the date of the change will be the greatest of the following: ( )

a. Reserves calculated ignoring the guarantee; ( )

b. Reserves assuming the guarantee was made at issue; and ( )

c. Reserves assuming that the policy was issued on the date of the guarantee. ( )

06. Reserve Adequacy. 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 chapter. 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 the Actuarial and Memorandum Rule, IDAPA 18.07.10, Section 022, "Statement of Actuarial Opinion Based on an Asset Adequacy Analysis." ( )

012. CALCULATION OF MINIMUM VALUATION STANDARD FOR POLICIES WITH GUARANTEED NONLEVEL GROSS PREMIUMS OR GUARANTEED NONLEVEL BENEFITS (OTHER THAN UNIVERSAL LIFE POLICIES).

01. Basic Reserves. Basic reserves are be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy will 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 below may be made: ( )

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

b. Treat the guaranteed cash surrender value, if greater than zero (0), applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero (0), applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment. ( )

02. Deficiency Reserves. ( )

a. The deficiency reserve at any duration will be calculated: ( )

i. On a unitary basis if the corresponding basic reserve determined by Subsection 012.01 is unitary; ( )

ii. On a segmented basis if the corresponding basic reserve determined by Subsection 012.01 is segmented; or ( )

iii. On the segmented basis if the corresponding basic reserve determined by Subsection 012.01 is equal to both the segmented reserve and the unitary reserve. ( )

b. Subsection 012.02 applies to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in Subsection 011.02 and rate of interest). ( )

c. Deficiency reserves, if any, are be calculated for each policy as the excess if greater than zero (0), for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Subsection 011.02. ( )

d. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves. ( )

03. Minimum Value. Basic reserves will not be less than the tabular cost of insurance for the balance

of the policy year, if mean reserves are used. Basic reserves will 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 will 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 will be the ten (10) 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. ( )

04. Unusual Pattern of Guaranteed Cash Surrender Values. ( )

a. 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 will 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. ( )

b. The reserves actually held subsequent to any unusual guaranteed cash surrender value will 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: ( )

i. *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: ( )

(1) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or ( )

(2) The mandatory expiration date of the policy; and ( )

ii. 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 ( )

iii. The net to gross ratio is equal to Item One (1) divided by Item Two (2) as follows: ( )

(1) 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. ( )

(2) The present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period. ( )

c. For purposes of Subsection 012.04, 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: ( )

i. One hundred ten percent (110%) of the scheduled gross premium for that year; ( )

ii. One hundred ten percent (110%) of one (1) 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 ( )

iii. Five percent (5%) of the first policy year surrender charge, if any. ( )

05. Optional Exemption for Yearly Renewable Term (YRT) Reinsurance. At the option of the

company, the following approach for reserves on YRT reinsurance may be used: ( )

a. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year; ( )

b. Basic reserves will never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 012.03; ( )

c. Deficiency reserves. ( )

i. For each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium. ( )

ii. Deficiency reserves will never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph 012.05.c.i.; ( )

d. For purposes of Subsection 012.05, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten (10) year select mortality factors, or any other table adopted after the effective date of this chapter by the NAIC and promulgated by rule by the Director for this purpose; ( )

e. A reinsurance agreement will be considered YRT reinsurance for purposes of Subsection 012.05 if only the mortality risk is reinsured; and ( )

f. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit will be limited to the amount of reserve held by the assuming company for the affected policies. ( )

06. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the company's option, the following approach for reserves for attained-age-based YRT life insurance policies may be used: ( )

a. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year. ( )

b. Basic reserves will never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 012.03. ( )

c. Deficiency reserves: ( )

i. For each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium. ( )

ii. Deficiency reserves will never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph 012.06.c.i. ( )

d. For purposes of Subsection 012.06, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten (10) year select mortality factors, or any other table adopted after March 30, 2001, by the NAIC and promulgated by rule for this purpose. ( )

e. A policy is considered an attained-age-based YRT life insurance policy for purposes of Subsection 012.06 if: ( )

i. 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 ( )

ii. 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. ( )

f. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of Subsection 012.06 may be used after the initial period if: ( )

i. The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or ( )

ii. The initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and ( )

iii. After the initial period of coverage, the policy meets the conditions of Paragraph 012.06.e.; and ( )

g. If this election is made, this approach will be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this chapter. ( )

07. Exemption from Unitary Reserves for Certain n-Year Renewable Term Life Insurance Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met: ( )

a. 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 ten (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; ( )

b. 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 (10) year select mortality factors; and ( )

c. There are no cash surrender values in any policy year. ( )

08. 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: ( )

a. At issue, the insured is age twenty-four (24) or younger; ( )

b. Until the insured reaches the end of the juvenile period, which will occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and ( )

c. 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. ( )

013. CALCULATION OF MINIMUM VALUATION STANDARD FOR FLEXIBLE PREMIUM AND FIXED PREMIUM UNIVERSAL LIFE INSURANCE POLICIES THAT CONTAIN PROVISIONS RESULTING IN THE ABILITY OF A POLICY OWNER TO KEEP A POLICY IN FORCE OVER A SECONDARY GUARANTEE PERIOD.

01. General. ( )

a. Policies with a secondary guarantee include: ( )

i. 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; ( )

ii. A policy in which the minimum premium at any duration is less than the corresponding one (1) year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten (10) year select mortality factors, or any other table adopted after March 30, 2001, by the NAIC and promulgated by rule for this purpose; or ( )

iii. A policy with any combination of Subparagraphs 013.01.a.i. and 013.01.a.ii. ( )

b. 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 will 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 will be considered to have been made at issue. Reserves described in Subsections 013.02 and 013.03 below will be recalculated from issue to reflect these changes. ( )

c. 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. ( )

d. For purposes of Section 013, the minimum premium for any policy year is the premium that, when paid into a policy with a zero (0) account value at the beginning of the policy year, produces a zero (0) account value at the end of the policy year. The minimum premium calculation will use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue. ( )

e. The one (1) year valuation premium means the net one (1) year premium based upon the original schedule of benefits for a given policy year. The one (1) year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Paragraphs 011.02.b., 011.02.c., and 011.02.d. cannot be used to calculate the one (1) year valuation premiums. ( )

f. The one (1) 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. ( )

02. Basic Reserves for the Secondary Guarantees. Basic reserves for the secondary guarantees will be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums will 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 Subsection 010.02. ( )

03. Deficiency Reserves for the Secondary Guarantees. Deficiency reserves, if any, for the secondary guarantees will be calculated for the secondary guarantee period in the same manner as described in Subsection 012.02 with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force. ( )

04. Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of: ( )

a. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or ( )

b. The minimum reserves prescribed by other rules or rules governing universal life plans. ( )

014. -- 999. (RESERVED)

18.07.04 – ANNUAL FINANCIAL REPORTING

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 6, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.04, "Annual Financial Reporting." ( )

02. Scope. To improve the Department's surveillance of the financial condition of insurers by requiring: (1) an annual audit of the 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. Insurers having direct premiums written in this state of less than one million dollars ($1,000,000) in any calendar year and less than one thousand (1,000) policyholders or certificate holders of direct written policies nationwide at the end of such calendar year are exempt from this rule for such 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 or treaties of reinsurance of one million dollars ($1,000,000) or more, or both, will not be exempt. Foreign or alien insurers filing the audited financial report in another state, pursuant to that other state's requirement for filing of audited financial reports found by the Director to be substantially similar to the requirements herein, are exempt from Section 011 through Section 020 of this rule if conditions of Subsection 001.02.a. or 001.02.b., of this rule apply: ( )

a. 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 in Sections 011, 018, and 019 respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada). ( )

b. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Director pursuant to Section 017. ( )

c. Foreign or alien insurers need 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 Director of the other state within the time specified. ( )

d. This rule does not prohibit, preclude or in any way limit the Director from ordering, conducting or performing examinations of insurers pursuant to the provisions of Title 41, Idaho Code, and the rules, practices and procedures of the Department. ( )

002. INCORPORATION BY REFERENCE.
This rule incorporates by reference the full text of the National Association of Insurance Commissioners Financial Condition Examiners Handbook and the National Association of Insurance Commissioners Annual Statement Instructions and Accounting Practices and Procedures Manual, pursuant to Sections 41-223 and 47-335, Idaho Code. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Affiliate. Is a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. ( )

02. Audit Committee. 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, and 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 (1) or more of these controlled insurers solely for the purposes of this rule at the election of the controlling person. Refer to Subsection 021.05 of this rule, for exercising this election. If an Audit committee is not designated by the insurer, the insurer's entire board of directors constitutes the Audit committee. ( )

03. Audited Financial Report. Includes those items specified in Section 012 of this rule. ( )

04. Indemnification. 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 or other misrepresentations made by the insurer or its representatives. ( )

05. Group of Insurers. Those licensed insurers included in the reporting requirements of Title 41, Chapter 38, Idaho Code, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting. ( )

06. Internal Control over Financial Reporting. A process effected by an entity's board of directors, management and other personnel providing reasonable assurance of the reliability of the financial statements, such as those items specified in Subsections 012.02 through 012.07 of this rule, 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, such as those items specified in Subsections 012.02 through 012.07 of this rule, 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, such as those items specified in Subsections 012.02 through 012.07 of this rule. ( )

07. Section 404. Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder. ( )

08. Section 404 Report. 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 3A. ( )

13. SOX Compliant Entity. An entity that needs to be compliant with, or voluntarily is compliant with, the following provisions of the Sarbanes-Oxley Act of 2002: ( )

a. The preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); ( )

b. The Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and ( )

c. The Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K). ( )

011. GENERAL REQUIREMENTS RELATED TO FILING AND EXTENSIONS FOR FILING OF ANNUAL AUDITED FINANCIAL REPORTS AND AUDIT COMMITTEE APPOINTMENT.

01. Annual Audit Filing Date. All insurers will have an annual audit by an independent certified public accountant and 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 (90) days advance notice. ( )

02. Request for Extension. Extensions of the June 1 filing date may be granted by the Director for thirty (30) day periods upon a showing by the insurer and its independent certified public accountant of the reasons for the request and a determination by the Director of good cause for an extension. The request for extension needs to be submitted in writing at least ten (10) days prior to the due date in sufficient detail to permit the Director to make an

informed decision with respect to the extension. If an extension is granted, an extension of thirty (30) days is also granted to the filing of Management's Report of Internal Control over Financial Reporting. ( )

03. Designation of Audit Committee. Every insurer needs to file an annual audited financial report pursuant to this chapter will designate an Audit committee, as defined in Section 010. The Audit committee of an entity controlling an insurer may be deemed to be the insurer's Audit committee for purposes of this rule at the controlling person's election. ( )

012. CONTENTS OF ANNUAL AUDITED FINANCIAL REPORT.

01. Contents of Report. The annual audited financial report will report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile. The annual Audited financial report will include the following: ( )

a. Report of independent certified public accountant; ( )

b. Balance sheet reporting admitted assets, liabilities, capital and surplus; ( )

c. Statement of operations; ( )

d. Statement of cash flow; ( )

e. Statement of changes in capital and surplus; ( )

f. Notes to financial statements, which will those prescribed by the appropriate NAIC Annual Statement Instructions and NAIC Accounting Practices and Procedures Manual. The notes will include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 41-335, Idaho Code, or other applicable section of Idaho Code with a written description of the nature of these differences. ( )

g. The financial statements included in the audited financial report will 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. The financial statement will be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (In the first year in which an insurer needs to file an audited financial report, the comparative data may be omitted.) ( )

013. DESIGNATION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

01. Registration with the Director. Each insurer prescribed by this rule to file an annual audited financial report needs, within sixty (60) days after becoming subject to the requirement, to 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. Insurers not retaining an independent certified public accountant on the effective date of this rule will register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed. ( )

02. Letter of Awareness. The insurer will 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 Department's rules of the state of domicile that relate to accounting and financial matters and affirming that they will express his opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Department, specifying appropriate exceptions. ( )

03. Dismissal or Resignation. If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer will within five (5) business days notify the Department. The insurer will also furnish the Director with a separate letter within ten (10) business days after the above notification stating whether in the twenty-four (24) months preceding such 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 disagreements, 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 need to be reported in response to this rule include those resolved to the former accountant's satisfaction and not resolved to the former accountant's satisfaction. Disagreements contemplated by this section occur at the decision-making level, such as between personnel of the insurer responsible for presentation of financial statements and personnel of the accounting firm responsible for rendering the report. The insurer will also in writing 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 which the accountant does not agree; and the insurer will furnish such responsive letter from the former accountant to the Director with its own. ( )

014. QUALIFICATIONS OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

01. In Good Standing. The Director will not recognize any person or firm as a qualified independent certified public accountant that is not in good standing with the AICPA 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 has either directly or indirectly entered into an agreement of indemnity or release from liability ("indemnification") with respect to the insurer's audit. ( )

02. Conformance with Ethical and Professional Standards. Except as otherwise provided in this rule, the Director will recognize an independent certified public accountant as qualified if the accountant conforms to the standards contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Idaho Board of Public Accountancy, or similar code. ( )

03. Resolution of Disputes and Delinquency Proceedings. A qualified independent certified public accountant may enter into an agreement with an insurer to have audit-related disputes resolved by mediation or arbitration. In the event of a delinquency proceeding commenced against the insurer under Title 41, Chapter 33, the mediation or arbitration provisions operates at the option of the statutory successor. ( )

04. Capacity to Render Report for Consecutive Years. The lead (or coordinating) audit partner (primarily responsible for the audit) cannot act in the capacity for more than five (5) consecutive years. The person will be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the Director for relief from the above requirement due to unusual circumstances. Application should be made at least thirty (30) days before the end of the calendar year. The Director may consider the following factors in determining if the relief should be granted: ( )

a. Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm; ( )

b. Premium volume; or ( )

c. Number of jurisdictions in which the insurer transacts business. ( )

05. Relief from Limitation on Consecutive Appointment of Lead Partner. The insurer will file, with its annual statement filing, the approval for relief from Subsection 014.04 of this rule, with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer will file the approval in an electronic format acceptable to the NAIC. ( )

06. Grounds for Not Recognizing as Qualified. The Director will neither recognize as a qualified independent certified public accountant, nor accept any annual Audited financial report, prepared in whole or in part by, any natural person who: ( )

a. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law; ( )

b. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or ( )

c. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this rule. ( )

07. Hearings. The Director of insurance may, as provided in Chapter 52, Title 67 and Chapter 2, Title 41, Idaho Code and IDAPA 04.11.01, 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 opinion on the financial statements in the annual Audited financial report made pursuant to this rule and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this rule. ( )

08. Banned Services. The Director will not recognize as a qualified independent certified public accountant, nor 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: ( )

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer; ( )

b. Financial information systems design and implementation; ( )

c. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports. ( )

d. 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: ( )

i. Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions; ( )

ii. The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and ( )

iii. The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves; ( )

e. Internal audit outsourcing services; ( )

f. Management functions or human resources; ( )

g. Broker or dealer, investment adviser, or investment banking services; ( )

h. Legal services or expert services unrelated to the audit; or ( )

i. Any other services that the Director determines, by rule, are impermissible. ( )

09. Principles of Independence. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three (3) basic principles, violations of which would impair the accountant's independence. The principles are that the accountant: ( )

a. Cannot function in the role of management; ( )

b. Cannot audit his own work; and ( )

c. Cannot serve in an advocacy role for the insurer. ( )

10. Exemption from Banned Services. Insurers having direct written and assumed premiums of less than one hundred million dollars ($100,000,000) in any calendar year may request an exemption from Subsection 014.08 of this rule. The insurer will file with the Director a written statement discussing the reasons why the insurer should be exempt from these provisions. If the Director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer, an exemption may be granted. ( )

11. Permitted Non-Audit Services. 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 014.08 of this rule, or that do not conflict with Subsection 014.09 of this rule, only if the activity is approved in advance by the Audit committee, in accordance with Subsection 014.12 of this rule. ( )

12. Preapproval Requisite by Audit Committee. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer will be preapproved by the Audit committee. The preapproval 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 ( )

a. The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) 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; ( )

b. The services were not recognized by the insurer at the time of the engagement to be non-audit services; and ( )

c. 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 (1) 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. ( )

13. Delegation by Audit Committee. The Audit committee may delegate to one (1) or more designated members of the Audit committee the authority to grant the preapprovals prescribed by Subsection 014.12 of this rule. The decisions of any member to whom this authority is delegated will be presented to the full Audit committee at each of its scheduled meetings. ( )

14. Prior Employment Banned. The Director will 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 (1) year period preceding the date that the most current statutory opinion is due. Subsection 014.14 of this rule, will only apply to partners and senior managers involved in the audit. ( )

a. An insurer may make application to the Director for relief from Subsection 014.14 of this rule, on the basis of unusual circumstances. ( )

b. The insurer will file, with its annual statement filing, the approval for relief from Subsection 014.14 of this rule, with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer will file the approval in an electronic format acceptable to the NAIC. ( )

015. CONSOLIDATED OR COMBINED AUDITS.

An insurer may make written application to the Director for approval to file 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 (100%) reinsurance agreement that affects the solvency and

integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet will be filed with the report, as follows: ( )

01. Worksheet. Amounts shown on the consolidated or combined Audited financial report will be shown on the worksheet; ( )

02. Separate Amounts. Amounts for each insurer subject to this section will be stated separately; ( )

03. Noninsurance Operations. Noninsurance operations may be shown on the worksheet on a combined or individual basis; ( )

04. Explanations of Consolidating and Eliminating Entries. Explanations of consolidating and eliminating entries will be included; and ( )

05. Reconciliation. A reconciliation will be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statement of the insurers. ( )

016. SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.
Financial statements furnished pursuant to Section 012 hereof will be examined by the independent certified public accountant. The audit of the insurer's financial statements will be conducted in accordance with generally accepted auditing standards. The independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent prescribed by the standards of his profession, for those insurers prescribed to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 023, the independent certified public accountant should consider (as that term is defined in generally accepted auditing standards) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration will be given to the other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary. ( )

017. NOTIFICATION OF ADVERSE FINANCIAL CONDITION.
The insurer needed to furnish the annual Audited financial report will require the independent certified public accountant to report, in writing, within five (5) 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 requirements of Title 41, Idaho Code, as of that date. An insurer that has received a report pursuant to this paragraph will forward a copy of the report to the Director within five (5) business days of receipt of the report and will 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 such evidence within the mandatory five (5) business day period, the independent certified public accountant will furnish to the Director a copy of its report within the next five (5) business days. No independent certified public accountant will be liable in any manner to any person for any statement made in connection with Section 017 if the statement is made in good faith in compliance with Section 017. If the accountant, subsequent to the date of the Audited financial report filed pursuant to this rule, becomes aware of facts which might have affected his report, the Director notes the obligation of the accountant to take action as prescribed by the standards of his profession. ( )

018. COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS NOTED IN AN AUDIT.
In addition to the annual audited financial report, each insurer will 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 will be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and will contain a description of any unremediated material weakness (as the term material weakness is defined by the standards of his profession) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in Subsection 011.01, of this rule) in the insurer's Internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state. The insurer needs 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. ( )

019. ACCOUNTANT'S LETTER OF QUALIFICATION.
The accountant will furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating: ( )

01. Independence. That the accountant is independent with respect to the insurer and conforms to the standards of his profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Idaho Board of Public Accountancy, or similar code; ( )

02. Background and Experience. 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 rule will be construed as prohibiting the accountant from utilizing such staff as he deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards; ( )

03. Compliance with Rule. That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this rule and that the Director will be relying on this information in the monitoring and regulation of the financial position of insurers; ( )

04. Consent to Requirements of Section 020. That the accountant consents to the requirements of Section 020 of this rule 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 020; ( )

05. Properly Licensed. 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 ( )

06. Compliance with Section 014. A representation that the accountant is in compliance with the requirements of Section 014 of this rule. ( )

020. DEFINITION, AVAILABILITY AND MAINTENANCE OF CERTIFIED PUBLIC ACCOUNTANTS WORKPAPERS.
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 company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his audit of the financial statements of an insurer and which support the accountant's opinion. Every insurer needs to file an Audited financial report pursuant to this rule, will require the accountant to make available for review by the insurance 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 office of the insurer, at the insurance department or at any other reasonable place designated by the Director. The insurer will require that the accountant retain the audit workpapers and communications until the insurance department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report. In the conduct of the aforementioned periodic review by the insurance. department examiners, it will be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners will be considered investigations and all working papers and communications obtained during the course of such investigations will be afforded the same confidentiality as other examination workpapers generated by the department. ( )

021. REQUIREMENTS FOR AUDIT COMMITTEES.
This section will 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. ( )

01. Responsibility. The Audit committee will 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 chapter. Each accountant will report directly to the Audit committee. ( )

02. Corporate Membership. Each member of the Audit committee will need to 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 021.05 and Section 010 of this rule. ( )

03. Independence. In order to be considered independent for purposes of Section 021, a member of the Audit committee will not, other than in his 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 will 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 (1) of its affiliates. ( )

04. Continuation of Service. 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 (1) year from the occurrence of the event that caused the member to be no longer independent. ( )

05. Controlling Person. To exercise the election of the controlling person to designate the Audit committee for purposes of this rule, the ultimate controlling person will provide written notice to the directors of insurance of the affected insurers. Notification will 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 needs to include a description of the basis for the change. The election will remain in effect for perpetuity, until rescinded. ( )

06. Accountant's Reports to Audit Committee. The Audit committee will require the accountant that performs for an insurer any audit prescribed by this rule to timely report to the Audit committee in accordance with the standards of his profession. If an insurer is a member of an insurance holding company system, the reports prescribed by Subsection 021.06 of this rule, 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. The accountant's reports need to include: ( )

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. ( )

07. Requisite Proportion of Independent Audit Committee Members. The proportion of independent Audit committee members will 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 will be independent. See also Note A and B.	Supermajority of members (75% or more) will be independent. See also Note A.

Prior Calendar Year Direct Written and Assumed Premiums
Note A: The Director has authority afforded by state law to require the entity'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 will be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

( )

08. Hardship Waiver. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than five hundred million dollars ($500,000,000) may make application to the Director for a waiver from the Section 021 requirements based upon hardship. The insurer will file, with its annual statement filing, the approval for relief from Section 021 with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer will file the approval in an electronic format acceptable to the NAIC. ( )

022. CONDUCT OF INSURER IN CONNECTION WITH THE PREPARATION OF REQUISITE REPORTS AND DOCUMENTS.

01. False or Misleading Statements. No director or officer of an insurer may, directly or indirectly make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication prescribed under this chapter. ( )

02. Omissions. No director or officer of an insurer may, directly or indirectly 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 prescribed under this chapter. ( )

03. Coercion. No officer or director of an insurer, or any other person acting under the direction thereof, may 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 chapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading. For purposes of Subsection 022.03 of this rule, 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: ( )

a. 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); ( )

b. Not to perform audit, review or other procedures prescribed by generally accepted auditing standards or other professional standards; ( )

c. Not to withdraw an issued report; or ( )

d. Not to communicate matters to an insurer's Audit committee. ( )

023. MANAGEMENT'S REPORT OF INTERNAL CONTROL OVER FINANCIAL REPORTING.

01. Premium Threshold. Every insurer needs to file an audited financial report pursuant to this chapter that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of five hundred million dollars ($500,000,000) or more will prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in Section 010. The report will be filed with the Director along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 018. Management's Report of Internal Control over Financial Reporting will be as of December 31 immediately preceding. ( )

02. RBC Level or Other Event. Notwithstanding the premium threshold in Subsection 023.01 of this rule, 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 (1) or more of the standards of an insurer deemed to be in hazardous financial condition as defined in IDAPA 18.07.05, "Director's Authority for Companies Deemed to be in Hazardous Financial Condition." ( )

03. Section 404. An insurer or a group of insurers may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section 023 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 Subsections 012.02 through 012.07 of this rule) were included in the scope of the Section 404 Report. The addendum will 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 Subsections 012.02 through 012.07 of this rule) 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: ( )

a. A Section 023 report; or ( )

b. The Section 404 Report and a Section 023 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, providing the insurer or group of insurers is: ( )

i. Directly subject to Section 404; ( )

ii. Part of a holding company system whose parent is directly subject to Section 404; ( )

iii. Not directly subject to Section 404 but is a SOX Compliant Entity; or ( )

iv. A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity. ( )

04. Requisite Elements. Management's Report of Internal Control over Financial Reporting will include: ( )

a. A statement that management is responsible for establishing and maintaining adequate Internal control over financial reporting; ( )

b. 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; ( )

c. A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its Internal control over financial reporting; and ( )

d. A statement that briefly describes the scope of work that is included and whether any internal controls were excluded; ( )

e. Disclosure of any unremediated material weaknesses in the Internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to 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 is one (1) or more unremediated material weaknesses in its Internal control over financial reporting; ( )

f. A statement regarding the inherent limitations of internal control systems; and ( )

g. Signatures of the chief executive officer and the chief financial officer (or equivalent position/title). ( )

05. Documentation by Management. Management will document and make available upon financial condition examination the basis upon which its assertions, prescribed in Subsection 023.04 of this rule, 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. Management may 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. Management's Report on Internal Control over Financial Reporting, prescribed by Subsection 023.01 of this rule, and any documentation provided in support thereof during the course of a financial condition examination, will be kept confidential by the Idaho Department of Insurance. ( )

024. EXEMPTIONS AND EFFECTIVE DATES.

01. Exemptions Not Otherwise Provided. Upon written application of any insurer, the Director may grant an exemption from compliance with any and all provisions of this rule if the Director finds, upon review of the application, that compliance with this rule 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 (10) days from a denial of an insurer's written request for an exemption from this chapter, the insurer may request in writing a hearing on its application for an exemption. The hearing will be held in accordance with the IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," pertaining to administrative hearing procedures. ( )

02. Alternate Effective Date for Section 021 [Requirements for Audit Committees]. An insurer or group of insurers that is not prescribed to have independent Audit committee members or only a majority of independent Audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one (1) of the independence requirements due to changes in premium will have one (1) year following the year the threshold is exceeded to comply with the independence requirements. Likewise, an insurer that becomes subject to one (1) of the independence requirements as a result of a business combination will have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements. ( )

03. Effective Date for Section 023 [Management's Report of Internal Control Over Financial Reporting]. An insurer or group of insurers that is not prescribed to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements will have two (2) years following the year the threshold is exceeded to file a report. Likewise, an insurer acquired in a business combination will have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements. ( )

025. CANADIAN AND BRITISH COMPANIES.

01. Annual Audited Financial Report. In the case of Canadian and British insurers, the annual audited financial report is 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. ( )

02. Letter Requisite in Section 013. For such insurers, the letter prescribed in Section 013 states that the accountant is aware of the requirements relating to the annual Audited statement filed with the Director pursuant to section 011 and affirms that the opinion expressed is in conformity with such requirements. ( )

026. INTERNAL AUDIT FUNCTION REQUIREMENTS.

01. Exemption. An insurer is exempt from the requirements of this section if: ( )

a. 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 five hundred million dollars ($500,000,000); and ( )

b. 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 one billion dollars ($1,000,000,000). ( )

02. Function. The insurer or group of insurers need to 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 will 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. ( )

03. Independence. In order to ensure that internal auditors remain objective, the internal audit function needs to be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and will 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. ( )

04. Reporting. The head of the internal audit function will 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. ( )

05. 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. ( )

027. MINIMUM RESERVE STANDARDS.

In addition to the requirements in this rule, unless otherwise prescribed or permitted, the minimum reserve standards for individual and group health insurance contracts set forth in the NAIC Accounting Practices and Procedures Manual apply to all individual and group health (disability) insurance coverages including single premium credit disability insurance. All other credit insurance is not subject to this section. ( )

028. -- 999. (RESERVED)

18.07.05 – DIRECTOR'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 3, and 33, Sections 41-211, 41-327 and 41-3309, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.05, "Director's Authority for Companies Deemed to be in Hazardous Financial Condition." ( )

02. Scope. This rule establishes standards that the Director may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance. This rule cannot be interpreted to limit the powers granted the Director by any laws or parts of laws of this state, nor supersedes any laws or parts of laws of this state. ( )

002. INCORPORATION BY REFERENCE.
This rule incorporates by reference the full text of the National Association of Insurance Commissioners (NAIC) Financial Condition Examiners Handbook and the NAIC Annual Statement Instructions and Accounting Practices and Procedures Manual, pursuant to Sections 41-223 and 41-335, Idaho Code. ( )

003. -- 010. (RESERVED)

011. STANDARDS.
The following standards, either singly or in combination of two (2) or more, may be considered by the Director to determine whether the continued operation of any insurer transacting insurance business in this state might be deemed to be hazardous to its policyholders or creditors or to the general public. The Director may consider: ( )

01. Examination Reports. Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries. ( )

02. NAIC Insurance Regulatory Information System. The NAIC Regulatory Information System and its other financial analysis solvency tools and reports. ( )

03. Adequate Cash Provision. Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows needed by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts. ( )

04. Reinsurance Program. The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer. ( )

05. Operating Loss (50% of Surplus). Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum mandatory. ( )

06. Operating Loss (20% of Surplus). Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum mandatory. ( )

07. Insolvency of Affiliate, Subsidiary or Reinsurer. Whether a reinsurer, obligor, or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations, and which in the opinion of the Director may affect the solvency of the insurer. ( )

08. Contingent Liabilities. Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the Director may affect the solvency of the insurer. ( )

09. Controlling Person. Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer. ( )

10. Receivables. The age and collectibility of receivables. ( )

11. Competence of Management. Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position. ( )

12. Failure to Respond to Inquiries. Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry. ( )

13. Failure to Meet Filing Requirements. Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Director. ( )

14. False or Misleading Financial Statements. Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer. ( )

15. Extensive Growth. Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner. ( )

16. Cash Flow. Whether the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems. ( )

17. Reserves Compliance with Minimum Standards. Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice. ( )

18. Material Under-Reserving. Whether management persistently engages in material under-reserving that results in adverse development. ( )

19. Transactions Among Affiliates. Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets, capital gains or both do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature. ( )

20. Any Other Finding. Any other finding determined by the Director to be hazardous to the insurer's policyholders or creditors or to the general public. ( )

012. DIRECTOR'S AUTHORITY.

01. Determination of Financial Condition. For the purposes of making a determination of an insurer's financial condition under this rule, the Director may: ( )

a. Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding; ( )

b. Make appropriate adjustments, including disallowance, to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates, consistent with the NAIC Accounting Policies and Procedures Manual, state laws, and regulations; ( )

c. Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; ( )

d. Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve (12) month period. ( )

02. Issuance of Order. If the Director determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or creditors or to the general public, then the Director may, upon a determination, issue an order requiring the insurer to: ( )

a. Reduce the total amount of present and potential liability for policy benefits by reinsurance; ( )

b. Reduce, suspend or limit the volume of business being accepted or renewed; ( )

c. Reduce general insurance and commission expenses by specified methods; ( )

d. Increase the insurer's capital and surplus; ( )

e. Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders; ( )

f. File reports in a form acceptable to the Director concerning the market value of an insurer's assets; ( )

g. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Director deems necessary; ( )

h. Document the adequacy of premium rates in relation to the risks insured; ( )

i. File, in addition to regular annual statements, interim financial reports on the form adopted by the NAIC or in such format as promulgated by the Director; ( )

j. Correct corporate governance practice deficiencies and adopt and utilize governance practices acceptable to the Director; ( )

k. Provide a business plan to the Director in order to continue to transact business in the state; or ( )

l. Adjust rates for any non-life insurance product written by the insurer that the Director considers necessary to improve the financial condition of the insurer. ( )

03. Hearing. Any insurer subject to an order under Subsection 012.02 may request a hearing to review that order pursuant to Title 41, Chapter 2, Idaho Code. ( )

013. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 3, and 5, Sections 41-211, 41-335, 41-510, 41-511, 41-512 and 41-514, Idaho Code. ( )

001. TITLE, PURPOSE AND SCOPE.

01. Title. IDAPA 18.07.06, "Rules Governing Life and Health Reinsurance Agreements." ( )

02. Purpose. To set forth standards for Reinsurance Agreements involving life insurance, annuities, or accident and sickness insurance (disability) in order that the financial statements of the life and health and property and casualty insurers writing health business and utilizing such agreements properly reflect the financial condition of the ceding and assuming insurer. ( )

a. The Department 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 011 violate Idaho Code Sections 41-1306, 41-515, 41-308(3), 41-327 and 41-3309: ( )

03. Applicability. This rule applies to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers that are not subject to a substantially similar rule in their domiciliary state. This rule also similarly applies to licensed property and casualty insurers with respect to their accident and health business. This rule does not apply to assumption reinsurance or yearly renewable term reinsurance. ( )

002. -- 010. (RESERVED)

011. ACCOUNTING REQUIREMENTS.

01. Standards for Credit on Financial Statement. No insurer subject to this rule will, 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: ( )

a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover 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; ( )

b. 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, will not be considered to be such a deprivation of surplus or assets; ( )

c. The ceding insurer needs 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 will 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; ( )

d. The ceding insurer needs to, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded; ( )

e. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the insured 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; ( )

f. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identified 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 will be consistent with this table. ( )

i. Risk categories: ( )

(1) Morbidity. ( )

(2) Mortality. ( )

ii. 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. ( )

iii. 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. ( )

iv. 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. ( )

v. 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

Key: + - Significant
0 - Insignificant

	i.	ii.	iii.	iv.	v.	vi.
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

	i.	ii.	iii.	iv.	v.	vi.
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

( )

g. Significant Risk. ( )

i. 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 IDAPA 18.07.06.011.01.g.ii.) 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 Director which legally segregates, by contract or contract provision, the underlying assets. ( )

ii. Notwithstanding the requirements of IDAPA 18.07.06.011.01.g.i., 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 needs to use a formula that 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 as reported in Annual Statement

"CG" is capital gains less capital losses as reported in Annual Statement

"X" is the current year cash and invested assets plus investment income due and accrued less borrowed money as reported in Annual Statement

"Y" is the same as X but for the prior year ( )

h. 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. ( )

i. The ceding insurer needs to make representations or warranties not reasonably related to the business being reinsured. ( )

j. The ceding insurer needs to make representations or warranties about future performance of the business being reinsured. ( )

k. 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. ( )

02. Director's Approval. An insurer subject to this Rule may, with the prior approval of the Director, take such reserve credit or establish such asset as the Director may deem consistent with the Insurance Code and Rules, including actuarial interpretations or standards adopted by the Department. ( )

03. Filing of Reinsurance Agreements. ( )

a. Agreements entered into after the effective date of this Rule which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, will be filed by the ceding company with the Director within thirty (30) days from its date of execution. Each filing will 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 will consider his Rule 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 Rule. ( )

b. Any increase in surplus net of federal income tax resulting from arrangements described in Subsection 011.03.a. will 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 line of the Annual Statement) and recognition of the surplus increase as income will be reflected on a net of tax basis in the "Reinsurance ceded" line of the annual statement as earnings emerge from the business reinsured. ( )

i. For example: On the last day of calendar year N, company XYZ pays a twenty ($20) million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a thirty-four percent (34%) tax rate, the net increase in surplus at inception is thirteen point two ($13.2) million (twenty ($20) million - six point eight ($6.8) million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. Six point eight ($6.8) million (thirty-four (34%) of twenty ($20) million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations. ( )

ii. At the end of year N+1 the business has earned four ($4) million. ABC has paid point five ($.5) million in profit and risk charges in arrears for the year and has received a one million ($1) million experience refund. Company ABC's annual statement would report one point six five ($1.65) million (sixty-six percent (66%) of (four ($4) million - one ($1) million - point five ($.5) million) up to a maximum of thirteen point two ($13.2) million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -one point sixty five ($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. ( )

012. WRITTEN AGREEMENTS.

01. Execution Date. 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. ( )

02. Letter of Intent. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement needs to 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. ( )

03. Requisite Provisions. The reinsurance agreement will contain provisions that provide that: ( )

a. The agreement will 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 ( )

b. Any change or modification to the agreement will be null and void unless made by amendment to the agreement and signed by both parties. ( )

013. EXISTING AGREEMENTS.
Insurers subject to this rule will not be allowed to recognize any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this rule which, under the provisions of this rule would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements will have been in compliance with laws or rules in existence immediately preceding the effective date of this rule. ( )

014. -- 999. (RESERVED)

18.07.08 – PROPERTY AND CASUALTY ACTUARIAL OPINION RULE

000. LEGAL AUTHORITY.
Title 41, Chapters 2, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.08, "Property and Casualty Actuarial Opinion Rule." ( )

02. Scope. This rule applies to annual statements filed with the Director as of the end of the first full calendar year following the effective date of the rule, and applies to all property and casualty companies doing business in this State. This rule is intended to provide the Director with additional means to monitor an insurer's loss reserves in accordance with Section 41-610, Idaho Code. ( )

002. -- 020. (RESERVED)

021. ACTUARIAL OPINION OF RESERVES AND SUPPORTING DOCUMENTATION.

01. Statement of Actuarial Opinion, Opinion Summary and Actuarial Report and Work Papers. ( )

a. Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, will annually submit the opinion of an Appointed Actuary entitled "Statement of Actuarial Opinion." This opinion will be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions. ( )

b. Every property and casualty insurance company domiciled in this state that is needs to submit a Statement of Actuarial Opinion will annually submit an Actuarial Opinion Summary, written by the company's Appointed Actuary. This Actuarial Opinion Summary will be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and will be considered to be a document supporting the Actuarial Opinion prescribed in Subsection 021.01 of this chapter. ( )

c. A company licensed but not domiciled in this state will provide the Actuarial Opinion Summary upon request. ( )

d. An Actuarial Report and underlying work papers as prescribed by the appropriate NAIC Property and Casualty Annual Statement Instructions will be prepared to support each Actuarial Opinion. ( )

e. If the insurance company fails to provide a supporting Actuarial Report or work papers at the request of the Director, or, after review, the Director determines the supporting Actuarial Report or work papers provided by the insurance company do not comply with the NAIC Property and Casualty Annual Statement Instructions or are otherwise unacceptable, the Director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion, and to prepare the supporting Actuarial Report or work papers. ( )

022. CONFIDENTIALITY.

01. The Statement of Actuarial Opinion. Will be provided with the Annual Statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and treated as a public document. ( )

02. Actuarial Report. ( )

a. Documents, materials or other information in the possession or control of the Department that are considered an Actuarial Report, work papers or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the Director in connection with the Actuarial Report, work papers or Actuarial Opinion Summary, will be considered to be exempt from public disclosure under Section 74-107(5), Idaho Code, of the Idaho Public Records Act. ( )

b. This provision cannot be construed to limit the Director's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is needed for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the Director regarding disclosure of the documents, nor be construed to limit the Director's authority to use the documents, materials or

other information in furtherance of any regulatory or legal action brought as part of the Director's official duties. ( )

03. Waiver. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information occurs as a result of disclosure to the director in Section 022. ( )

023. -- 999. (RESERVED)

18.07.09 – LIFE AND HEALTH ACTUARIAL OPINION AND MEMORANDUM RULE

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.07.09, "Life and Health Acutarial Opinion and Memorandum Rule." ( )

02. Application of Rule. This rule applies to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation will be applied in a manner that allows the appointed actuary to utilize their 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 will 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. ( )

03. Application to All Annual Statements. This rule will be applicable to all annual statements filed with the office of the Director after the effective date. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 022 of this chapter, and a memorandum in support thereof in accordance with Section 023 of this chapter, will be needed each year. ( )

04. Purpose. The purpose of this rule is to prescribe: ( )

a. Guidelines and standards for statements of actuarial opinion which are to be submitted in accordance with Section 41-612(12), Idaho Code, and for memoranda in support thereof; ( )

b. Rules applicable to the appointment of an appointed actuary; and ( )

c. Guidelines as to the meaning of adequacy of reserves. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Actuarial Opinion. The opinion of an Appointed Actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy test in accordance with Section 022 of this chapter and with presently accepted Actuarial Standards. ( )

02. Actuarial Standards Board. The board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice. ( )

03. Asset Adequacy Analysis. An analysis that meets the standards and other requirements referred to in Subsection 021.04 of this chapter. It may take many forms, including, but not limited to, cash flow testing, sensitivity testing or applications of risk theory. ( )

04. Company. A life insurance company, fraternal benefit society or reinsurer subject to the provisions of this rule. ( )

011. -- 020. (RESERVED)

021. GENERAL REQUIREMENTS.

01. Submission of Statement of Actuarial Opinion. ( )

a. There is to be included on or attached to Page one (1) of the annual statement for each year beginning with the year in which this rule becomes effective 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 022 of this chapter. ( )

b. Upon written request by the company, the Director may grant an extension of the date for submission of the statement of actuarial opinion. ( )

02. Qualified Actuary. An individual who: ( )

a. Is a member in good standing of the American Academy of Actuaries; and ( )

b. 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; and ( )

c. Is familiar with the valuation requirements applicable to life and health insurance companies; and ( )

d. 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; ( )

i. Violated any provision of, or any obligation imposed by any law in the course of their dealings as a qualified actuary; or ( )

ii. Been found guilty of fraudulent or dishonest practices; or ( )

iii. Demonstrated incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary; or ( )

iv. Submitted to the Director during the past five (5) years, pursuant to this rule, an actuarial opinion or memorandum that the Director rejected because it did not meet the provisions including standards set by the Actuarial Standards Board; or ( )

v. 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 ( )

e. Has not failed to notify the Director of any action taken by any Director of any other state similar to that under Subsection 021.02.d. of this chapter. ( )

03. Appointed Actuary. A qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion prescribed by this rule; either directly by or by the authority of the board of directors through an executive officer of the company. The company will 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 will state in such notice that the person meets the requirements set forth in Subsection 021.02 of this chapter. Once notice is furnished, no further notice is prescribed with respect to this person, provided that the company will 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 021.02 of this chapter. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice will so state and give the reasons for replacement. ( )

04. Standards for Asset Adequacy Analysis. The asset adequacy analysis prescribed by this rule: ( )

a. Will conform to the Standards of Practice as promulgated by the Actuarial Standards Board and on any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with Section 021 of this chapter; and ( )

b. Will be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board. ( )

05. Liabilities to Be Covered. ( )

a. Under authority of Section 41-612(12), Idaho Code, the statement of actuarial opinion will apply to all in force business on the statement date regardless of when or where issued, e.g., Aggregate Reserve for Life Contracts, Aggregate Reserve for Accident and Health Contracts, reserves for Deposit Type Contracts, and Claims for Life and Health Contracts as reported in Exhibits of the annual statement, and equivalent items in the separate account statement or statements of the annual statement. ( )

b. 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 Section 41-612(12), Idaho Code, the company will establish such additional reserve. ( )

c. Additional reserves established under Subsections 021.05.a. or 021.05.b. of this chapter and deemed not necessary in subsequent years may be released. Any amounts released needs to 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. ( )

022. STATEMENT OF ACTUARIAL OPINION BASED ON AN ASSET ADEQUACY ANALYSIS.

01. General Description. The statement of actuarial opinion submitted in accordance with this section will consist of; ( )

a. A paragraph identifying the appointed actuary and qualifications (see Subsection 022.02.a. of this chapter); ( )

b. 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 which have been analyzed for asset adequacy and the method of analysis, (see Subsection 022.02.b. of this chapter) and identifying the reserves and related actuarial items covered by the opinion which have not been so analyzed; ( )

c. 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 022.02.c. of this chapter), supported by a statement of each such expert in the form prescribed by Subsection 022.05 of this chapter; and ( )

d. An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Subsection 022.02.f. of this chapter). ( )

e. One (1) or more additional paragraphs will be needed in individual company cases as follows; ( )

i. If the appointed actuary considers it necessary to state a qualification of his opinion; ( )

ii. If the appointed actuary needs to 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; ( )

iii. If the appointed actuary needs to disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release; or ( )

iv. If the appointed actuary chooses to add a paragraph briefly describing the assumptions which form the basis for the actuarial opinion. ( )

02. Recommended Language. The Department has adopted recommended language which can be obtained on the Department's website and 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 which clearly expresses their professional judgment. However, in any event the opinion will

retain all pertinent aspects of the language provided. ( )

03. Assumptions for New Issues. The adoption for new issues or new claims or other new liabilities of an actuarial assumption which 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 022 of this chapter. ( )

04. Adverse Opinions. If the appointed actuary is unable to form an opinion, then they will refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then they will issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for such opinion. This statement should follow the scope paragraph and precede the opinion paragraph. ( )

05. Reliance on Data 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 will 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 will 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. ( )

023. ALTERNATE OPTION.

01. Standard Valuation Law. 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 part (c) in Paragraph 022.02.f. of this chapter, the Director may make one (1) 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 will be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year will apply to statements for that calendar year, and they will 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 prescribed 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 will be issued no later than March 31 of the year it is first effective. It will remain valid until rescinded or modified by the Director. The rescission or modifications will 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 will file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request will 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 prescribed 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 prescribed comparison will be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year will apply to statements for that calendar year, and it will 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 will 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 will 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 will 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 will 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. ( )

d. 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 with an independent actuary at the company's expense to prepare and file the opinion. ( )

024. DESCRIPTION OF ACTUARIAL MEMORANDUM INCLUDING AN ASSET ADEQUACY ANALYSIS AND REGULATORY ASSET ADEQUACY ISSUES SUMMARY.

01. General. ( )

a. In accordance with Section 41-612(12), Idaho Code, the appointed actuary will prepare a memorandum to the company describing the analysis done in support of their opinion regarding the reserves. The memorandum will be made available for examination by the Director upon his request but will be returned to the company after such examination and cannot be considered a record of the insurance department or subject to automatic filing with the Director. ( )

b. In preparing the memorandum, the appointed actuary may rely on, and include as a part of their own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Subsection 021.02 of this chapter, with respect to the areas covered in such memoranda, and so state in their memoranda. ( )

c. 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 Rule, the Director may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is needed for review. The reasonable and necessary expense of the independent review will be paid by the company but will be directed and controlled by the Director. ( )

d. The reviewing actuary will have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary will be retained by the Director; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers will be considered as examination workpapers and will be kept confidential to the same extent as is prescribed by Section 41-227, Idaho Code. The reviewing actuary cannot be an employee of a consulting firm involved with the

preparation of any prior memorandum or opinion for the insurer pursuant to this rule for any one of the current year or the preceding three (3) years. ( )

e. In accordance with Section 41-612(12), Idaho Code, the appointed actuary will prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection 024.03 of this chapter. 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 mandatory. The regulatory asset adequacy issues summary will be maintained as confidential and not subject to public disclosure by the director in accordance with Section 41-612(12), Idaho Code, and Section 74-107(5) of the Idaho Public Records Act. ( )

f. In accordance with Section 41-612(12)(d)(iv), the director will accept the regulatory asset adequacy issues summary of a foreign or alien company filed by that company with the insurance supervisory official of another state if the director determines that the summary reasonably meets the requirements applicable to a company domiciled in Idaho. Therefore, foreign or alien insurers needed to file the regulatory asset adequacy issues summary in their home state are exempt from filing in this state, except upon request of the director, provided the other state has substantially similar reporting requirements and the summary is filed with the director of the other state within the time specified. ( )

02. Details of the Memorandum Section Documenting Asset Adequacy Analysis (Section 022). When an actuarial opinion under Section 022 of this chapter is provided, the memorandum will demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Subsection 021.04 of this chapter and any additional standards under this rule. It will specify; ( )

a. For reserves; ( )

i. Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant; ( )

ii. Source of liability in force; ( )

iii. Reserve method and basis; ( )

iv. Investment reserves; ( )

v. Reinsurance arrangements; and ( )

vi. 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. ( )

b. 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. ( )

ix. The documentation of the assumptions will be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. ( )

c. For assets: ( )

i. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets; ( )

ii. Investment and disinvestment assumptions; ( )

iii. Source of asset data; ( )

iv. Asset valuation bases. ( )

d. Documentation of assumptions made for the following assets: ( )

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. ( )

vi. The documentation of the assumptions will be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. ( )

e. For the analysis basis: ( )

i. Methodology; ( )

ii. Rationale for inclusion/exclusion of different blocks of business and how pertinent risks were analyzed; ( )

iii. 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); ( )

iv. 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); ( )

v. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis. ( )

f. Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis; ( )

g. Summary of Results; ( )

h. Conclusion(s). ( )

i. The regulatory asset adequacy issues summary will include: ( )

i. 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 will 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; ( )

ii. 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; ( )

iii. 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; ( )

iv. Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; ( )

v. 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 ( )

vi. 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. ( )

j. The regulatory asset adequacy issues summary will contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and will be signed and dated by the appointed actuary rendering the actuarial opinion. ( )

04. Conformity to Standards of Practice. The memorandum will 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." ( )

05. 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, needs to 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 cannot 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 needs to 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 needs to be disclosed in the memorandum. ( )

06. Documentation. The appointed actuary will 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. ( )

025. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 64, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.10, "Corporate Governance Annual Disclosure." ( )

02. Scope. This rule sets forth procedures for filing and the necessary content of the Corporate Governance Annual Disclosure (CGAD) to carry out the provisions of Title 41, Chapter 64, Idaho Code. ( )

002. INCORPORATION BY REFERENCE.
The most recent National Association of Insurance Commissioners (NAIC) Financial Analysis Handbook (2016 Annual / 2017 Quarterly edition) is incorporated by reference into IDAPA 18.07.10. ( )

003. – 009. (RESERVED)

010. DEFINITIONS.

01. Senior Management. Any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and will 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 chief or "C" level executive. ( )

011. FILING PROCEDURES.

01. Filing Deadline. An insurer, or the insurance group of which the insurer is a member, needs to file a CGAD by Title 41, Chapter 64, Idaho Code, no later than June 1 of each calendar year, submit to the director a CGAD that contains the information described in Section 012 of this rule. ( )

02. Signature. The CGAD needs to 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 (board) or the appropriate committee thereof. ( )

03. Format. The insurer or insurance group will have discretion regarding the appropriate format for providing the information prescribed by this rule 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. ( )

04. Providing Information. 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 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 will indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting. ( )

05. Completion on Insurance Group Level. Notwithstanding Subsection 011.01, and as outlined in Section 41-6403, Idaho Code, if the CGAD is completed at the insurance group level, then it needs to 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 needs to also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request. ( )

06. Referencing. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., Own Risk Solvency Assessment (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 012. The insurer or insurance group will 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. ( )

07. Filing of Amended Versions. Each year following the initial filing of the CGAD, the insurer or insurance group will file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state. ( )

012. CONTENTS OF CORPORATE GOVERNANCE ANNUAL DISCLOSURE.

01. Detail. The insurer or insurance group will 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. ( )

02. CGAD Considerations. The CGAD will describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following: ( )

a. 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 will describe and discuss the rationale for the current board size and structure; and ( )

b. 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. ( )

03. Factors. The insurer or insurance group will describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors: ( )

a. How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group. ( )

b. How an appropriate amount of independence is maintained on the board and its significant committees. ( )

c. The number of meetings held by the board and its significant committees over the past year as well as information on director attendance. ( )

d. How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example: ( )

i. Whether a nomination committee is in place to identify and select individuals for consideration. ( )

ii. Whether term limits are placed on directors. ( )

iii. How the election and re-election processes function. ( )

iv. Whether a board diversity policy is in place and if so, how it functions. ( )

e. 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). ( )

04. Additional Factors. The insurer or insurance group will describe the policies and practices for

directing senior management, including a description of the following factors: ( )

a. 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: ( )

i. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed. ( )

ii. 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. ( )

b. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example: ( )

i. Compliance with laws, rules, and regulations; and ( )

ii. Proactive reporting of any illegal or unethical behavior. ( )

c. 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 will 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: ( )

i. The board's role in overseeing management compensation programs and practices. ( )

ii. 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; ( )

iii. How compensation programs are related to both company and individual performance over time; ( )

iv. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels; ( )

v. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; ( )

vi. 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. ( )

d. The insurer’s or insurance group’s plans for CEO and senior management succession. ( )

05. Oversight. The insurer or insurance group will 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: ( )

a. How oversight and management responsibilities are delegated between the board, its committees and senior management; ( )

b. 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; ( )

c. 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: ( )

i. Risk management processes (An ORSA summary report filer may refer to its ORSA summary report pursuant to Title 41, Chapter 63, Idaho Code); ( )

ii. Actuarial function; ( )

iii. Investment decision-making processes; ( )

iv. Reinsurance decision-making processes; ( )

v. Business strategy/finance decision-making processes; ( )

vi. Compliance function; ( )

vii. Financial reporting/internal auditing; and ( )

viii. Market conduct decision-making processes. ( )

013. – 999. (RESERVED)

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. IDAPA 18.08.01, "Adoption of the International Fire Code." ( )

02. Scope. Pursuant to the authority provided by Section 41-253, Idaho Code, the State Fire Marshal adopts the International Fire Code as the minimum standard for the protection of life and property from fire and explosion in the state of Idaho. All such editions and appendices will be adopted in accordance with Section 67-5229, Idaho Code. ( )

002. -- 009. (RESERVED)

010. CONSTRUCTION AND DESIGN PROVISIONS, SECTION 102.1, INTERNATIONAL FIRE CODE.
Delete Item No. 3 of Section 102.1, International Fire Code. ( )

011. DEPARTMENT OF FIRE PREVENTION, SECTION 103.2 -- APPOINTMENTS, INTERNATIONAL FIRE CODE.
Delete the following language in section 103.2 of the International Fire Code: "… and the fire code official shall not be removed from office except for cause and after full opportunity to be heard on specific and relevant charges by and before the appointing authority." ( )

012. GENERAL AUTHORITY AND RESPONSIBILITIES, SECTION 104.1, INTERNATIONAL FIRE CODE.
Add the following second paragraph to Section 104.1, General, International Fire Code: ( )

01. Fire Chief's Authority. The fire chief is authorized to administer and enforce this code. Under the chief's direction, the fire department is authorized to enforce all ordinances of the jurisdiction pertaining to: ( )

a. The prevention of fires; ( )

b. The suppression or extinguishment of dangerous or hazardous fires; ( )

c. The storage, use and handling of hazardous materials; ( )

d. The installation and maintenance of automatic, manual and other private fire alarm systems and fire- extinguishing equipment; ( )

e. The maintenance and regulation of fire escapes; ( )

f. The maintenance of fire protection and the elimination of fire hazards on land and in buildings, and other property, including those under construction; ( )

g. The maintenance of means of egress; and ( )

h. The investigation of the cause, origin and circumstances of fire and unauthorized releases of hazardous materials, for authority related to control and investigation of emergency scenes, see Section 104.11. ( )

013. -- 015. (RESERVED)

016. PERMIT REQUISITE, SECTION 105.1.1, INTERNATIONAL FIRE CODE.
Delete "the required permit" from the last sentence of Section 105.1.1 of the International Fire Code and add "a permit if needed by the authority having jurisdiction." ( )

017. VIOLATION PENALTIES, SECTION 110.4, INTERNATIONAL FIRE CODE.
In the first sentence of Section 110.4 of the International Fire Code, delete "[SPECIFY OFFENCE], punishable by a fine of not more than [AMOUNT] dollars, or by imprisonment not exceeding [NUMBER OF DAYS], or both such

fine and imprisonment" and add the word "misdemeanor". ( )

018. FAILURE TO COMPLY, SECTION 112.4, INTERNATIONAL FIRE CODE.
In Section 112.4, International Fire Code, delete this entire section. ( )

019. SECTION 202, INTERNATIONAL FIRE CODE.

01. Fire Code Official. Add "or as appropriate the Idaho State Fire Marshal" to the end of the definition for FIRE CODE OFFICIAL in Section 202 of the International Fire Code. ( )

02. Driveway. Add "DRIVEWAY. A vehicular ingress and egress route that serves no more than five (5) single family dwellings, not including accessory structures." ( )

03. Fire Station. Add "FIRE STATION, A building, or portion of a building that provides, at a minimum, all weather protection for fire apparatus. Temperatures inside the building used for this purpose need to be maintained at above thirty-two (32) degrees Fahrenheit." ( )

020. SKY LANTERNS, SECTION 308.1.6.3, INTERNATIONAL FIRE CODE.

01. Untethered Sky lanterns. To section 308.1.6.3 delete the sentence: "A person cannot release or cause to be released an untethered sky lantern." ( )

02. Sky lantern permit. To section 308.1.6.3 add the following: "A person cannot release or cause to be released a sky lantern, tethered or untethered without obtaining a permit, if required by the fire code or jurisdiction. When, in the opinion of the fire code official, the release of sky lanterns, tethered or untethered, constitutes a danger to persons or property, based on the current weather conditions, knowledge of topography, vegetation, or any other reasonable factor, is authorized to require additional safeguards prior to the release of sky lanterns. The fire code official may suspend, revoke, postpone, or prohibit the release of any sky lantern at any time." ( )

021. MOBILE FOOD PREPARATION VEHICLES, SECTION 319, INTERNATIONAL FIRE CODE.

01. Permit Required. To Section 319.2, International Fire Code, add permissive language: "IF REQUIRED BY A LOCAL JURISDICTION, permits may be required as set forth in Section 105.6." ( )

02. Fuel Gas Systems. To Section 319.10.3, International Fire Code, add permissive language: "IF REQUIRED BY THE LOCAL JURISDICTION, LP-gas containers installed on the vehicle and fuel-gas piping systems may be inspected annually by an approved inspection agency or a company that is registered with the U.S. Department of Transportation to requalify LP-gas cylinders, … Upon satisfactory inspection, the approved inspection agency shall affix a tag on the fuel gas system or within the vehicle indicating the name of the inspection agency and the date of satisfactory inspection, OR PROVIDE DOCUMENTATION OF INSPECTION UPON REQUEST OF THE LOCAL JURISDICTION." ( )

022. CHAPTER 5 FIRE SERVICE FEATURES.
Make the following changes within Chapter 5 of the International Fire Code; ( )

01. Section 501. ( )

a. To section 501.3 after the phrase, Construction documents for proposed, add the word "driveways." ( )

b. To section 501.4 after the phrase, When fire apparatus access roads, add the word "driveways." ( )

02. Section 502. ( )

a. To section 502, add the following word "DRIVEWAY." ( )

b. To section 502, add the words "FIRE STATION." ( )

03. Section 503. ( )

a. To section 503 add the words, "AND DRIVEWAYS" to the section heading. ( )

b. To section 503.1.1 add the following sentence, "Driveways need to be provided and maintained in accordance with Sections 503.1.1 through 503.1.3." ( )

c. To section 503.6 delete the sentence, "The installation of security gates across a fire apparatus access road shall be approved by the fire chief." ( )

d. Add the following section, "503.7 Driveways. Need be provided when any portion of an exterior wall of the first story of a building is located more than 150 feet (45720mm) from a fire apparatus access road. Driveways will provide a minimum unobstructed width of 12 feet (3658mm) and a minimum unobstructed height of 13 feet 6 inches (4115mm). Driveways in excess of 150 feet (45720mm) in length need to be provided with turnarounds. Driveways in excess of 200 feet (60960mm) in length and less than 20 feet (6096mm) in width may require turnouts in addition to turnarounds." ( )

e. Add the following section, "503.7.1 Limits. A driveway cannot serve in excess of five single family dwellings." ( )

f. Add the following section, "503.7.2 Turnarounds. Driveway turnarounds need to have an inside turning radius of not less than 30 feet (9144mm) and an outside turning radius of not less than 45 feet (13716mm). Driveways that connect with an access road or roads at more than one point may be considered as having a turnaround if all changes of direction meet the radius requirements for driveway turnarounds." ( )

g. Add the following section, "503.7.3 Turnouts. Where line of sight along a driveway is obstructed by a man-made or natural feature, turnouts need to be located as may be needed by the fire code official to provide for safe passage of vehicles. Driveway turnouts will be of an all-weather road surface at least 10 feet (3048mm) wide and 30 feet (9144mm) long." ( )

h. Add the following section, "503.7.4 Bridge Load Limits. Vehicle load limits will be posted at both entrances to bridges on driveways and private roads. Design loads for bridges will be established by the fire code official." ( )

i. Add the following section, "503.7.5 Address markers. All buildings need to have a permanently posted address, which will be placed at each driveway entrance and be visible from both directions of travel along the road. In all cases, the address needs to be posted at the beginning of construction and maintained thereafter. The address need be visible and legible from the road on which the road on which the address is located. Address signs along one-way roads will be visible from both the intended direction of travel and the opposite direction. Where multiple address's are required at a single driveway, they need to be mounted on a single post, and additional signs will be posted at locations where driveways divide." ( )

j. Add the following section, "503.7.6 Grade. The gradient for driveways cannot exceed 10 percent unless approved by the fire code official." ( )

k. Add the following section, "503.7.7 Security Gates. Where security gates are installed, they need to have an approved means of emergency operation. The security gates and emergency operation will be maintained operational at all times." ( )

l. Add the following section, "503.7.8 Surface. Driveways need to be designed and maintained to support the imposed loads of local responding fire apparatus and will be surfaced as to provide all weather driving capabilities." ( )

04. Section 507. To section 507.2 Type of water supply, delete the existing language and add the

following, "A water supply will consist of water delivered by fire apparatus, reservoirs, pressure tanks, elevated tanks, water mains or other sources approved by the fire code official capable of providing the needed fire flow. Exception. The water supply prescribed by this code needs to apply to structures served by a municipal fire department or a fire protection district and within ten miles (16093m) of a responding fire station." ( )

023. -- 026. (RESERVED)

027. ALTERNATIVE AUTOMATIC FIRE-EXTINGUISHING SYSTEMS, SECTION 904.1.1, INTERNATIONAL FIRE CODE.
Add the following language to the beginning of section 904.1.1 of the International Fire Code, "If prescribed by the authority having jurisdiction,". ( )

028. PORTABLE FIRE EXTINGUISHERS, SECTION 906.2.1, INTERNATIONAL FIRE CODE.
Add the following language to the beginning of section 906.2.1 of the International Fire Code, "If prescribed by the authority having jurisdiction,". ( )

029. FIRE ALARM AND DETECTION SYSTEMS, SECTION 907.1, INTERNATIONAL FIRE CODE.
Notification Devices. When fire alarm systems not needed by the International Fire Code are installed, the notification devices need to meet the minimum design and installation requirements for systems that are prescribed by this code. Intent: (Non-prescribed fire alarm systems will provide the same level of occupant notification that prescribed systems provide). ( )

030. CONSTRUCTION REQUIREMENTS FOR EXISTING BUILDINGS, SECTION 1101.1, INTERNATIONAL FIRE CODE.
Add the following language to the end of section 1101.1 of the International Fire Code, "only, if in the opinion of the fire code official, they constitute a distinct hazard to life or property." ( )

031. EXPLOSIVES AND FIREWORKS, CHAPTER 56, INTERNATIONAL FIRE CODE.
Delete Sections 5601.1.3, 5601.2.2, 5601.2.3, 5601.2.4.1, 5601.2.4.2, and sections 5608.2, 5608.2.1, and 5608.3 of the International Fire Code. ( )

032. -- 045. (RESERVED)

046. UNDERGROUND TANKS OUT OF SERVICE FOR ONE YEAR, SECTION 5704.2.13.1.3 INTERNATIONAL FIRE CODE.
Add to Section 5704.2.13.1.3, International Fire Code, the following paragraph: Upon approval of the Chief underground tanks that comply with the performance standards for new or upgraded underground tanks set forth in Title 40 Section 280.20 or 280.21 of the Code of Federal Regulations may remain out of service indefinitely so long as they remain in compliance with the operation, maintenance and release detection requirements of the federal rule. ( )

047. -- 055. (RESERVED)

056. REFERENCES TO APPENDIX, INTERNATIONAL FIRE CODE.
The following appendixes of the International Fire Code are hereby adopted: ( )

01. Appendix B, Fire Flow Requirements for Buildings. ( )

02. Appendix C, Fire Hydrant Location and Distribution. ( )

03. Appendix D, Fire Apparatus Access Roads. ( )

a. To section D101.1 Scope, add the following sentence, "Driveways as described in section 503.7 through 503.7.8 are not subject to the requirements of this appendix." ( )

b. To section D102.1, after the phrase, by way of an approved fire apparatus access road, add the following "designed and maintained to support the imposed loads of the responding fire apparatus and will be

surfaced so as to provide all-weather driving capabilities." And delete the remainder of the section. ( )

c. To section D103.2 Grade. Add the following. "The gradient of the fire apparatus access road needs to be within the limits established by the fire code official based on the capabilities of the responding fire departments apparatus." Delete the remainder of the section and the exception. ( )

04. Appendix E, Hazard Categories. ( )

05. Appendix F, Hazard Rankings. ( )

057. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.02.01 – INSURANCE RATES AND CREDIT RATING

DOCKET NO. 18-0201-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211 and 41-1842, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule implements Title 41-1843 Idaho Code: No insurer regulated pursuant to this title shall charge a higher premium than would otherwise be charged, or cancel, non-renew or decline to issue a property or casualty policy or coverage based primarily upon an individual's credit rating or credit history. This rulemaking brings the rule back in line with statute. Stakeholders' feedback during the negotiated rulemaking process resulted in the clarifying changes to Section 100.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 13-15.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this November 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211 and 41-1842, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule implements Title 41-1843, Idaho Code: No insurer regulated pursuant to this title shall charge a higher premium than would otherwise be charged, or cancel, non-renew or decline to issue a property or casualty policy or coverage based primarily upon an individual's credit rating or credit history. This rulemaking brings the rule back in line with statute.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021.

Substantive changes have been made to the pending rule.
Italicized red text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0201-2101

18.02.01 – INSURANCE RATES AND CREDIT RATING

000. LEGAL AUTHORITY.
Title 41, Sections 41-211 and 41-1843, Idaho Code. ( )

001. SCOPE.
This rule relates to the use of credit rating or credit history by insurers subject to said sections. ( )

002. – 009. (RESERVED)

010. DEFINITIONS.
As used in this chapter, the following words have the following meanings: ( )

01. Consumer Report. Any written, oral, or other communication of any information by a consumer reporting agency regulated under the federal Fair Credit Reporting Act (15 U.S.C. 1681) that bears on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. ( )

02. Credit Factor. A factor or criterion that consists of or is derived from information obtained from a consumer report, and is used by an insurer in determining policy premium rates or in determining whether to issue, cancel, or nonrenew a policy. ( )

03. Noncredit Factor. Any factor other than a credit factor reasonably expected to affect the risk assumed by an insurer and used by the insurer in determining policy premium rates, or in determining whether to issue, cancel or nonrenew a policy. ( )

011. -- 099. (RESERVED)

100. USE OF CREDIT FACTORS.

01. Application of Statute. To determine whether a decision is not improperly based primarily upon a credit factor or factors, the Department will apply the following criteria: ( )

a. If an insurer declines to issue, nonrenews or cancels a policy based in any part upon a credit factor, then the insurer will maintain records demonstrating noncredit factors played a greater role in the decision than credit factors. ( )

b. If an insurer relies in any part upon a credit factor to establish an initial rate or to impose an increase in premium rate for a customer, then the insurer is to ensure the premium rate using the highest credit factor *does not exceed twice the premium using* the lowest credit factor, all noncredit factors being unchanged and notwithstanding any optional coverage. *( )*

02. Information For Review. To evaluate whether a decision was based primarily upon credit factors, the insurer will have on file with the Department, in a manner approved by the Director, an attestation that rate, insurance, non-renewal, and cancellation decisions are not primarily based on credit factors, and that the rating is compliant with Paragraph 100.01.b. of this rule. The insurer's filing will support the attestation by providing the details of the rating process, including an explanation of all factors considered in the rating process and how the process is applied. The Department may also request the insurer apply its rating process to hypothetical cases. ( )

101. -- 200. (RESERVED)

201. RETENTION OF RECORDS.
Insurers subject to this rule will document the factors and criteria considered in underwriting and rating decisions and will retain the documentation for at least five (5) years. ( )

202. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.03.05 – CREDIT LIFE AND CREDIT DISABILITY INSURANCE

DOCKET NO. 18-0305-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211 and 41-2314, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The purpose of this rule is to protect the interest of debtors and Idaho residents by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. This rulemaking clarifies language, removes duplicative language, and moves information to the Department's website.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 17-23.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211 and 41-2314, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this rule is to protect the interest of debtors and Idaho residents by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. This rulemaking clarifies language, removes duplicative language, and moves information to the Department's website.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021.

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0305-2101

18.03.05 – CREDIT LIFE AND CREDIT DISABILITY INSURANCE

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 23, Sections 41-211 and 41-2314, Idaho Code. ( )

001. SCOPE.
This rule protects the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. Nothing in this rule chapter applies to insurance for which no identifiable charge is made to the debtor. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
The definitions set forth in Chapters 2 and 23 are applicable to these rules. In addition, the following terms have the meanings set forth below. ( )

01. Closed-End Credit. A credit transaction that is not open-end credit. ( )

02. Compensation. Money or anything else of value. ( )

03. Credit Insurance. Means credit life insurance and credit disability insurance. ( )

04. Credit Transaction. Any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased, is to be made at a future date or dates. ( )

05. Identifiable Charge. The amount the debtor is charged for insurance which is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, and including any differential in finance, interest, service or other similar charge made to debtors who are in like circumstances, except for their insured or noninsured status. ( )

06. Net Written Premium. A gross written premium minus refunds on terminations. ( )

07. Open-End Credit. An arrangement as defined in Section 28-41-301(26), Idaho Code, including revolving charge accounts. ( )

08. Pre-existing Condition. A health condition, including sickness or injury, for which there has been medical advice, diagnosis or treatment within six (6) months preceding the effective date of the debtor's coverage and which exists prior to the effective date of the coverage. ( )

011. RIGHTS AND TREATMENT OF DEBTORS.

01. Multiple Plans of Insurance. If a creditor makes available to the debtors more than one (1) plan of credit life insurance or more than one (1) of credit disability insurance, all debtors are to be informed of all such plans for which they are eligible. ( )

02. Substitution. When a creditor requires credit life insurance, credit disability insurance, or both, as additional security for an indebtedness, the debtor will be given the option of furnishing the amount of insurance

through existing policies of insurance owned or controlled by the debtor or by procuring and furnishing the coverage through any insurer authorized to transact insurance business in this state. If this subsection is applicable, the debtor will be informed by the creditor of the right to provide alternative coverage before the transaction is completed. ( )

03. Termination of Group Credit Insurance Policy. ( )

a. If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, then provision will be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under such policy is to be continued for the entire period for which the single premium has been paid. ( )

b. If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, then the policy will provide that, in the event of termination of such policy for whatever reason, termination notice will be given to the insured debtor at least thirty (30) days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The requisite notice is given by the insurer or, at the option of the insurer, by the creditor. ( )

04. Interest on Premiums. If any direct or indirect finance, carrying, credit or service charge is made to the debtor on such insurance charges or premiums, the creditor will remit and the insurer will collect such premium within sixty (60) days after it is added to the indebtedness. ( )

05. Renewal or Refinancing of the Indebtedness. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force will be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of such termination prior to scheduled maturity, a refund is to be paid or credited to the debtor as provided in Section 017. In any renewal or refinancing of the indebtedness, the effective date of the coverage as respects any policy provision is deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least to the extent of the amount and term of the indebtedness outstanding at the time of renewal and refinancing of the debt. In addition, the policy will provide that, in the event the debtor becomes disabled while insured, credit disability insurance benefits will be payable during continued disability regardless of any termination of the insurance by renewal or refinancing, unless a different provision not less favorable to the debtor is approved by the Director. ( )

06. Maximum Aggregate Provisions. A provision in a policy or certificate that sets a maximum limit on total payments applies only to that policy or certificate except as may be provided for in Section 41-2005(4), Idaho Code. ( )

07. Involuntary Prepayment of Indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it is the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate: ( )

a. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit disability insurance premium in accordance with Section 017; ( )

b. In the case of prepayment by a lump sum disability claim, an appropriate refund of the credit life insurance premium in accordance with Section 017; ( )

c. In either case, the amount of the benefits in excess of the amount needed to repay the indebtedness after crediting any unearned interest or finance charges. ( )

08. Amounts to be Insured. If benefits to be provided are less than the scheduled amount of indebtedness, the insurer will notify the insured of such benefit in the policy or certificate. ( )

09. Total Disability. The policy is not to restrict coverage to those periods of total disability when the debtor is under the regular and continuing care of a physician, osteopath or chiropractor; provided, the insurer may retain the right to request medical evidence of actual total disability at reasonable intervals to justify the commencement and continued payment of benefits. ( )

10. Permanent Disabilities. Credit disability insurance will not restrict coverage to permanent disabilities, where the debtor is in fact totally disabled for the period dictated by the policy, although such disability may be of a temporary nature. ( )

11. Statement by Debtor. No statement made by a debtor will be used by the insurer as a basis for denying eligibility for coverage unless such statement is contained in a written application for insurance signed by the debtor. ( )

12. Acceptable Insurance Constituting Waiver. Acceptance of insurance by the insurer will constitute a waiver of any conditions for issuance of insurance that the debtor's application revealed as breached on the date the application was made, unless a refund of all insurance charges to the debtor is actually made within thirty (30) days of the effective date of coverage. ( )

012. (RESERVED)

013. DETERMINATION OF REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGE.

01. General Standard. Benefits provided by credit insurance policies need to be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or is expected to develop a loss ratio of not less than fifty percent (50%). The Department of Insurance has established prima facie rates as a means to achieve the loss ratio benchmark. With the exception of deviations approved under Section 019, prima facie rates filed in accordance with Section 014 as adjusted pursuant to Section 018, may be conclusively presumed to satisfy this general standard. ( )

02. Nonstandard Coverage. If any insurer files for approval of any form, providing coverage more restrictive than that described in Section 014, the insurer will demonstrate to the satisfaction of the director that the premium rates to be charged for such restricted coverage will develop or may reasonably be expected to develop a loss ratio not less than that contemplated for standard coverage at the premium rates described in these sections. ( )

014. PRIMA FACIE RATES.

01. Credit Life Insurance Prima Facie Rates. ( )

a. The Director will post on the Department's website the prima facie rates for credit life insurance that are to be used. ( )

b. If the benefits provided are other than those described in Paragraph 014.0l.a., premium rates for such benefits will be actuarially consistent with the rates provided in Paragraph 014.0l.a. ( )

c. If the policy provisions are other than those that correspond to the use of rates provided for in this subsection, those other provisions will not be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. ( )

02. Credit Disability Insurance Prima Facie Rates. ( )

a. The Director will post on the Department's website the credit disability insurance prima facie rates that are to be used. ( )

b. If the benefits provided are other than those described in Paragraph 014.02.a., rates for such

benefits need to be actuarially consistent with rates provided in Paragraph 014.02.a. ( )

c. The outstanding balance rate for credit disability insurance may be either a term-specified rate or may be a single composite term outstanding balance rate applicable to all loans. ( )

d. If the policy provisions are other than those that correspond to the use of rate provided for in this Subsection, those other provisions are not to be unfair, just, inequitable, misleading, or deceptive; encourage misrepresentations of the coverage; or be contrary to statute or administrative rule. ( )

015. CREDIT LIFE INSURANCE.
Premium rates in conformance with Section 014 apply to policies providing credit life insurance to be issued with or without evidence of insurability, to be offered to all debtors, and containing: ( )

01. Exclusions. No exclusions other than suicide within six (6) months of the incurred indebtedness; and ( )

02. Age Restrictions. Either no age restrictions or age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors having attained age seventy (70) or over on the maturity date of the indebtedness. ( )

03. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance, classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65). ( )

04. Closed-End Credit Plans. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, no provision excluding or denying a claim for death resulting from a pre-existing condition except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6) months preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within six (6) months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the advance or charge is posted to the plan account. Other more restrictive provisions may be used subject to appropriate rate adjustment approved by the director. ( )

05. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions are not to be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. ( )

016. CREDIT DISABILITY INSURANCE.
Premium rates in conformance with Section 014 apply to policies providing credit disability insurance to be issued with or without evidence of insurability, to be offered to all eligible debtors, and containing: ( )

01. Pre-existing Conditions. No provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6) months preceding the effective date of the debtor's coverage and which caused loss within the six (6) months following the effective date of coverage. ( )

02. Other Exclusions or Restrictions. No other provision which excludes or restricts liability in the event of disability caused in a specific manner except that it may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries or disability arising out of the commission of felony acts. ( )

03. Actively-at-Work Requirement. No actively-at-work requirement more restrictive than one (1) requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage. "Full time" means a regular work week of not less than thirty (30) hours. A debtor is actively at work if absent from work due solely to regular day off, holiday or paid vacation. ( )

04. Age Restrictions. No age restrictions, or only age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors who will have attained age sixty-six (66) or over on the maturity date of the indebtedness. ( )

05. Daily Benefit. A daily benefit equal in amount to one thirtieth (1/30) of the monthly benefit payable under the policy for the indebtedness. ( )

06. Definition of Disability. A definition of "disability" which provides that during the first twelve (12) months of disability the insured is unable to perform the substantial and material duties of his occupation at the time the disability occurred, and thereafter the duties of any occupation for which the insured is reasonably fitted by education, training or experience. This does not apply to lump sum disability coverage. ( )

07. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65). ( )

08. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions are not to be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. ( )

09. Effective Date of Coverage. For the purposes of Subsections 016.01 and 016.03, the effective date of coverage for each part of the insurance attributable to a different advance or charge to an open-end credit plan account is the date on which the advance or charge is posted to the plan account. ( )

017. REFUND FORMULAS.

01. Filing and Approval by the Director. Any refund formula that is at least as favorable to the insured debtor as the "sum of the digits" formula, or the "Rule of 78," for single premium decreasing or disability plans or pro-rata for other plans, will be deemed acceptable. ( )

02. Termination. In the event of termination, no charge for credit insurance may be made for the first fifteen (15) days of a loan month and a full month may be charged for sixteen (16) days or more of a loan month. ( )

03. Minimum Refund. No refund of five dollar ($5) or less need be made. ( )

018. EXPERIENCE REPORTS AND ADJUSTMENT OF PRIMA FACIE RATES.

01. Report of Credit Life and Credit Disability Business Written. Each insurer doing credit insurance business in this state will annually file with the Director and the NAIC Support and Services Office a report of credit life and credit disability business written on a calendar year basis. Such report will utilize the Credit Insurance Supplement-Annual Statement Blank as approved by the National Association of Insurance Commissioners. Such filing will be made in accordance with and no later than the due date in the Instructions to the Annual Statement. ( )

02. Review of Loss Ratio Standards. On a triennial basis beginning in 1995, the director will review the loss ratio standards set forth in Section 013 and the prima facie rates set forth in Section 014 and determine therefrom the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three years determined from the incurred claims and earned premiums at prima facie rates reported in the Annual Statement Supplement, and may, if deemed necessary, revise the actual statewide prima facie rates to be used by insurers during the next three (3) years. Such rates will reflect the difference between (a) actual claims based on experience; and (b) expected claims based on the loss ratio standards set forth in Section 013 applied to the prima facie rates set forth in Section 014. ( )

019. USE OF RATES - DIRECT BUSINESS ONLY.

01. Use of Prima Facie Rates. An insurer that files rates or has rates on file not in excess of the prima

facie rates shown in Section 014, to the extent adjusted pursuant to Section 018, may use those rates without further proof of their reasonableness. ( )

02. Use of Rates Higher Than Prima Facie Rates. An insurer may file for approval of and use rates higher than the prima facie rates established pursuant to Section 018, to the extent adjusted, if it can be expected that the use of such higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of such higher rates) not less than fifty percent (50%) for those accounts to which such higher rates apply and that such upward deviations will not result on a statewide basis for that insurer of a ratio of claims incurred to premiums earned of less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to Section 018. If rates higher than the prima facie rates shown in Section 014, to the extent adjusted pursuant to Section 018, are filed for approval, the filing will specify the accounts to which such rates apply. Such rates may be: ( )

a. Applied uniformly to all accounts of the insurer; or ( )

b. Applied on an equitable basis approved by the Director to only one (1) or more accounts of the insurer for which the experience has been less favorable than expected; or ( )

c. Applied according to a case-rating procedure on file with the director. ( )

03. Approval Period of Deviated Rates. ( )

a. A deviated rate will be in effect for a period of time not longer than the experience period used to establish such rate (i.e. one (1) year, two (2) years or three (3) years). An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve-month (12) period. ( )

b. Notwithstanding Subsection 019.01, if an account changes insurers, that rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on such account, if sooner. ( )

04. Use of Rates Lower Than Filed Rates. An insurer may at any time use a rate for an account lower than its filed rate without prior notice, justification and approval by the director. ( )

05. Terms and Definitions Applicable to This Section. ( )

a. "Experience" means "earned premiums" and "incurred claims" during the experience period. ( )

b. "Experience Period" means the most recent period of time for which experience is reported, but not for a period longer than three (3) full years. ( )

c. "Incurred Claims" means total claims paid during the experience period, adjusted for the change in claim reserve. ( )

020. SUPERVISION OF CREDIT INSURANCE OPERATIONS.

01. Responsibilities of Insurer. Each insurer transacting credit insurance in this state is responsible for the settlement, adjustment and payment of all claims and is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business with such creditors, to assure compliance with the insurance laws of this state and the rules promulgated by the Director. Such review needs to include, but not be limited to, a verification of the accuracy of premium payments or other identifiable charges, premium refunds, and claims incurred. ( )

02. Maintenance of Records. Records of such reviews will be maintained for four (4) years for review by the director. ( )

021. PRODUCER'S LICENSE NEEDED.

01. Life and Disability Insurance License or Limited License. Except as provided in this section, to solicit credit life and credit disability insurance, producer is: licensed to sell life and disability insurance; or issued an appropriate "Limited License". ( )

02. Administration of Group Policy. Under Section 41-1005(2)(b), Idaho Code, the issuance of group certificates of credit life insurance and credit disability insurance and the performance of other ministerial duties in connection with group insurance policy administration does not need the person doing such acts to be licensed as a producer provided that no commission is paid for such services. A group policyholder may be reimbursed its expense of administering a group policy without being licensed as a producer, and such reimbursement will not be considered a commission provided it is reasonably computed to equate to the actual administrative expenses. It will be presumed that an amount of reimbursement not exceeding ten percent (10%) of the net written prima facie premium for the group policy is reasonably computed to equate to the administrative expenses of the group policyholder. Amounts exceeding ten percent (10%) of the net written prima facie premium will be presumed to exceed actual administrative expenses unless prior approval to pay such greater amount is secured pursuant to the insurer demonstrating to the director's satisfaction that such higher amount does not exceed the policyholder's actual administrative expenses. For purposes of this subsection, "prima facie premium" means premiums at the rates set forth in Section 014 without adjustment pursuant to Section 018. ( )

022. DISCLOSURE.
When a premium or identifiable charge is payable by a debtor for credit insurance coverage offered by a creditor, at the time such insurance is applied for, disclosures will be made to the principal debtor and copies given and retained, in accordance with State and Federal law. The creditor will also disclose the optional nature of the coverage, premium or identifiable charge separately by type of coverage, eligibility requirements, and policy limitations and exclusions. These disclosures need to be made prominently above the space for the signature indicating election to obtain such coverage. These disclosures may be made in conjunction with either (1) the Federal Truth-in-Lending disclosure, (2) a Notice of Proposed Insurance, or (3) the insurance policy or certificate. ( )

023. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.01 – HEALTH CARRIER EXTERNAL REVIEW

DOCKET NO. 18-0401-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211, 41-5904, and 41- 5911, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule sets forth uniform requirements to be followed by health carriers and independent review organizations in implementing external review procedures in accordance with Title 41, Chapter 59, Idaho Code. This rulemaking facilitates the resolution of accountability and responsibility issues regarding services denied by health insurance carriers.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 24-26.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this November 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211, 41-5904, and 41-5911, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule sets forth uniform requirements to be followed by health carriers and independent review organizations in implementing external review procedures in accordance with Title 41, Chapter 59, Idaho Code. This rulemaking facilitates the resolution of accountability and responsibility issues regarding services denied by health insurance carriers.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021.

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0401-2101

18.04.01 – HEALTH CARRIER EXTERNAL REVIEW

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 59, Idaho Code. ( )

001. SCOPE.
This rule sets forth uniform requirements to be followed by health carriers and independent review organizations in implementing external review procedures in accordance with Title 41, Chapter 59, Idaho Code. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
The definitions set forth in Title 41, Chapter 2 and 59 are applicable to these rules. In addition, the following term has the following meaning: ( )

01. URAC. The nationally recognized private health care accreditation organization based in Washington, D.C., that accredits independent review organizations. ( )

011. -- 019. (RESERVED)

020. NOTICE OF RIGHT TO EXTERNAL REVIEW.

01. Disclosure to Covered Persons. Health carriers will provide external review procedures to covered persons as per Chapter 59, Title 41 and in manner as directed by the Department. ( )

02. Notice to Covered Person. In accordance with Chapter 59, Title 41: ( )

a. The written notice of the covered person's right to request an external review is to use the form posted on the Department's website or is substantially similar. Health carriers are to submit notice forms to the Director for approval; and ( )

b. The written notice sent by the health carrier as prescribed by this subsection is to include an authorization form to disclose protected health information in compliance with the federal regulation and in a manner as approved by the Department. ( )

021. REQUEST FOR EXTERNAL REVIEW.

01. Request Form. The form for a covered person to request an external review will be available from the Department and will be posted on the Department's web site. ( )

02. Authorization Form. The covered person's request for an external review is to include an authorization form to disclose protected health information prescribed in Paragraph 020.02.b. ( )

022. HEALTH CARRIER NOTICE OF INITIAL DETERMINATION OF AN EXTERNAL REVIEW REQUEST.
Health carriers are to use the form posted on the Department's website or one substantially similar as determined by the Department. ( )

023. APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS.

01. Application for Registration. Independent review organizations need to apply to the department on the requisite form and pay the applicable fees, as set forth at IDAPA 18.01.02, to be registered to perform external reviews. ( )

02. Notice to Director. ( )

a. An independent review organization will notify the Director in writing within thirty (30) days of the date the independent review organization is no longer accredited by a nationally recognized private accrediting entity or no longer satisfies the minimum requirements established under Title 41, Chapter 59, Idaho Code and this rule. ( )

b. Any change in the independent review organization's schedule of costs and fees for performing external reviews need to be submitted to the Director at least sixty (60) days before the effective date of the change. ( )

03. Termination of Approval. The Director may immediately terminate approval of an independent review organization if the independent review organization no longer satisfies the requirements of Title 41, Chapter 59, Idaho Code, and this rule. Notice of termination will be in writing to the independent review organization and such organization will be deleted from the list of organizations approved to perform external reviews. If the independent review organization is performing an external review at the time of termination, the independent review organization will cease performing that review and immediately forward all information and documentation to the Director. ( )

024. VOLUNTARY ELECTION BY ERISA PLAN ADMINISTRATOR.

01. Written Notice and Compliance. If a single employer self-funded ERISA employee benefit plan administrator or designee voluntarily elects to comply with Title 41, Chapter 59, Idaho Code, the administrator or designee will comply with all provisions of Title 41, Chapter 59, Idaho Code, and this rule, as if it were a health carrier and, in a manner, as approved by the department on forms posted on the Department's website. ( )

025. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.02 – COMPLICATIONS OF PREGNANCY, NEWBORN, AND ADOPTED CHILDREN COVERAGE

DOCKET NO. 18-0402-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule sets forth uniform requirements for providing coverage to newborn and newly adopted children in accordance with Sections 41-2140, 41-2210, 41-3437, 41-3923, 41-4023, and 41-4123, Idaho Code. This rulemaking clarifies language and incorporates the provisions of Rule No. 18.04.09 - Complications of Pregnancy.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 28-29.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 41-211, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule sets forth uniform requirements for providing coverage to newborn and newly adopted children in accordance with Sections 41-2140, 41-2210, 41-3437, 41-3923, 41-4023, and 41-4123, Idaho Code. This rulemaking clarifies language and incorporates the provisions of Rule No. 18.04.09 - Complications of Pregnancy.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021.

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0402-2101

18.04.02 – COMPLICATIONS OF PREGNANCY, NEWBORN, AND ADOPTED CHILDREN COVERAGE

000. LEGAL AUTHORITY.
Title 41, Chapter 2, Idaho Code. ( )

001. SCOPE.
This rule sets forth uniform definitions and requirements to be followed by health plans regarding involuntary complications of pregnancy and coverage to newborn and newly adopted children. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
As used in this chapter the following terms have the following meanings. ( )

01. Congenital Anomaly. A condition existing at or from birth that is a significant deviation from the common form or function of the body, impairing the function of the body, whether caused by a hereditary or developmental defect or disease. ( )

02. Health Plan. Any type of benefit plan or contract of coverage subject to the requirements of Title 41, Chapters 21, 22, 34, 39, 40, or 41, Idaho Code, which provides coverage for injury or sickness. ( )

03. Health Plan Member. A person entitled to benefits as a member, subscriber or insured under a health plan and who, under the terms of the health plan contract, may add dependents for coverage under the health plan. ( )

011. COVERAGE REQUIREMENTS OF NEWBORN AND NEWLY ADOPTED CHILDREN.

01. Coverage. A health plan will provide coverage to: ( )

a. A newborn child and ( )

b. A newly adopted child. ( )

02. Coverage Requirements. Coverage of newborn and newly adopted children will be at least equivalent to the coverage afforded other health plan members under the health plan and include coverage for the medically necessary care and treatment of congenital anomalies. ( )

03. Pre-Existing Conditions. A health plan cannot apply a pre-existing condition exclusion to a newborn or newly adopted child. ( )

04. Reconstructive Surgery. A health plan will not exclude reconstructive surgery for congenital anomalies. ( )

05. Limitations on Coverage for Congenital Anomalies. A health plan may apply exclusions, requirements or benefit limitations, including cost sharing requirements, to coverage for congenital anomalies that are consistent with the requirements of this chapter and no more restrictive than exclusions, requirements or benefit limitations applied to coverage for similar treatments, conditions and services provided under the health plan. ( )

06. Notification and Payment. ( )

a. If notice and payment of additional premium are needed for dependent coverage under the health plan contract, the contract may request notice of birth, placement or adoption and payment of associated premium as a condition of coverage for newborn and newly adopted children. The notification period cannot be less than sixty (60) days from the date of birth for a newborn child or, for newly adopted children, sixty (60) days from the earlier of the date of adoption or placement for adoption. The due date for payment of any additional premium, if requested, cannot be not less than thirty-one (31) days following receipt by the health plan member of a billing for the premium. ( )

b. All requirements for notice and payment of premium applied by the health plan for the enrollment of newborn or newly adopted children are to be clearly set forth in the health plan contract and provided to the health plan members in a manner reasonably calculated to provide notice to the members of the requirements. ( )

c. If the health plan member fails to provide the requested notification, or make the associated premium payment, the health plan may decline to enroll a dependent child as a newborn or newly adopted child, but will treat a newborn or newly adopted child no less favorably than it treats other applicants who seek coverage at a time other than when first eligible for coverage. ( )

d. For self-funded health care plans subject to Title 41, Chapter 40 or 41, Idaho Code, any references to premium in this chapter should be recognized to be applying to contributions. ( )

07. Portability. The coverage provided by this section applies to any subsequent health plans providing coverage to the newborn or newly adopted child. ( )

012. -- 020. (RESERVED)

021. COVERAGE OF INVOLUNTARY COMPLICATIONS OF PREGNANCY.
Involuntary complications of pregnancy, as that term is used in Title 41, Idaho Code, also includes but is not limited to: ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but not false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. ( )

022. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.07 – RESTRICTIONS ON DISCRETIONARY CLAUSES IN HEALTH INSURANCE CONTRACTS

DOCKET NO. 18-0407-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211, 41-1302, and 41- 1842, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule sets forth uniform requirements regarding the use of discretionary clauses to be followed by health carriers transacting insurance in Idaho. This chapter does not apply to a health insurance contract for group coverage offered by or through an employer to its employees. Title 41 Chapters 13 and 18 regulate trade practices and the insurance contract, respectively.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 31-31.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211, 41-1302, and 41-1842, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule sets forth uniform requirements regarding the use of discretionary clauses to be followed by health carriers transacting insurance in Idaho. This chapter does not apply to a health insurance contract for group coverage offered by or through an employer to its employees. Title 41 Chapters 13 and 18 regulate trade practices and the insurance contract, respectively.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0407-2101

18.04.07 – RESTRICTIONS ON DISCRETIONARY CLAUSES IN HEALTH INSURANCE CONTRACTS

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 13 and 18, Idaho Code. ( )

001. SCOPE.
This rule sets forth uniform requirements regarding the use of discretionary clauses to be followed by health carriers transacting insurance in Idaho. This chapter does not apply to a health insurance contract for group coverage offered by or through an employer to its employees. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Discretionary Clause. Any health insurance contract provision that provides the health carrier with sole discretionary authority to determine eligibility for benefits or to interpret the terms and provisions of the health insurance contract. ( )

03. Health Care Services. Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease. ( )

04. Health Carrier. An entity subject to regulation under Title 41, Chapters 21, 22, 32, 34, 39, 40, 41, 47, 52 or 55, Idaho Code. ( )

05. Health Insurance Contract. Any policy, contract, certificate, agreement, or other form or document providing, defining, or explaining coverage for health care services offered, delivered, issued for delivery, continued, or renewed in this state by a health carrier. ( )

011. DISCRETIONARY CLAUSES.
No health insurance contract may contain a discretionary clause. ( )

012. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.10 – MEDICARE SUPPLEMENT INSURANCE STANDARDS

DOCKET NO. 18-0410-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211, and 41-4404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rulemaking aligns the rule to statute regarding Medicare Supplement plans. It includes changes which will include community rating, prohibit issue age rating, and allow for an annual period during which a policyholder may change carriers.

Stakeholders' feedback during the negotiated rulemaking process resulted in minor adjustments to clarify language in Section 056.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 32-59.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this November 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211 and 41-4404, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this rule is to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act and this rulemaking incorporates changes enacted via passage of S1143.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021

Substantive changes have been made to the pending rule.
Italicized red text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0410-2101

18.04.10 – MEDICARE SUPPLEMENT INSURANCE STANDARDS

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 44, Idaho Code. ( )

001. SCOPE.

a. Except as specifically provided in Sections 046, 051, 066, and 077, this chapter applies to: ( )

i. All Medicare supplement policies delivered or issued for delivery in this state; and ( )

ii. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state. ( )

b. This chapter does not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) 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 organization. ( )

002. INCORPORATION BY REFERENCE.
This chapter incorporates by reference Appendixes A (Refund Calculation and Calculation of Benchmark forms Model Regulation 651 pages 651-94 to 651-97), B (Form for Reporting Medicare Supplement Policies, page 651-98), and C (Disclosure Statements pages 651-99 to 651-108), and all other outlines of coverage and specific plan designs of the National Association of Insurance Commissioners (NAIC) Model Regulation 651 (pages 651-42 to 651-85) implementing the Medicare supplement insurance minimum standards (2018). The Model Regulation is available from the National Association of Insurance Commissioners and from the Idaho Department of Insurance. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Applicant. ( )

a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and ( )

b. In the case of a group Medicare supplement policy, the proposed certificate holder. ( )

02. Bankruptcy. 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. ( )

03. Continuous Period of Creditable Coverage. 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. ( )

04. Creditable Coverage. ( )

a. With respect to an individual, coverage of the individual provided under any of the following: ( )

i. A group health plan; ( )

ii. Health insurance coverage; ( )

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare); ( )

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; ( )

v. Title 10, Chapter 55, United States Code (CHAMPUS); ( )

vi. A medical care program of the Indian Health Service or of a tribal organization; ( )

vii. A state health benefits risk pool; ( )

viii. A health plan offered under Title 5, Chapter 89, United States Code (Federal Employees Health Benefits Program); ( )

ix. A public health plan as defined in federal regulation; and ( )

x. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). ( )

b. Creditable coverage does not include one (1) or more, or any combination of, the following: ( )

i. Coverage only for accident or disability income insurance, or any combination thereof; ( )

ii. Coverage issued as a supplement to liability insurance; ( )

iii. Liability insurance, including general liability insurance and automobile liability insurance; ( )

iv. Workers' compensation or similar insurance; ( )

v. Automobile medical payment insurance; ( )

vi. Credit-only insurance; ( )

vii. Coverage for on-site medical clinics; and ( )

viii. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. ( )

c. Creditable coverage does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are not an integral part of the plan: ( )

i. Limited scope dental or vision benefits; ( )

ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any

combination thereof; and ( )

iii. Such other similar, limited benefits as are specified in federal regulations. ( )

d. Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits: ( )

i. Coverage only for a specified disease or illness; and ( )

ii. Hospital indemnity or other fixed indemnity insurance. ( )

e. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance: ( )

i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; ( )

ii. Coverage supplemental to the coverage provided under Title 10, Chapter 55, United States Code; and ( )

iii. Similar supplemental coverage provided to coverage under a group health plan. ( )

f. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addressed separate, noncoordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, credible coverage has been addressed in an interim final rule (62 Fed. Reg. At 16960-16962 (April 8, 1997)) issued by the Secretary of Health and Human Services, pursuant to HIPAA, and may be addressed in subsequent regulations. ( )

05. Employee Welfare Benefit Plan. A plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act). ( )

06. Insolvency. 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. ( )

07. Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes: ( )

a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; ( )

b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and ( )

c. Medicare Advantage private fee-for-service plans. ( )

08. Medicare Supplement Policy. As defined in Section 41-4402 and in addition, "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; provided, however, that under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) need to comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act. ( )

09. Pre-Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued prior to July 1, 1992. ( )

10. 1990 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued on or after July 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. ( )

11. 2010 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance with an effective date for coverage issued on or after June 1, 2010. ( )

12. Secretary. The Secretary of the United States Department of Health and Human Services. ( )

011. 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 which conform to the requirements of this section. ( )

01. Accident, Accidental Injury, or Accidental Means. To employ "result" language and does 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. ( )

a. The definition will 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." ( )

b. The definition may provide that injuries cannot 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 banned by law. ( )

02. Benefit Period or Medicare Benefit Period. Will not be defined more restrictively than as defined in the Medicare program. ( )

03. Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility. Will not be defined more restrictively than as defined in the Medicare program. ( )

04. Health Care Expenses. For purposes of Section 051, expenses of managed care organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. ( )

05. Hospital. 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. ( )

06. Medicare. Is defined in the policy and certificate, substantially 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." ( )

07. Medicare Eligible Expenses. Expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare. ( )

08. Physician. Will not be defined more restrictively than as defined in the Medicare program. ( )

09. Sickness. Will 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. ( )

012. POLICY PROVISIONS.

01. Medicare Supplement Policy. Except for permitted preexisting condition clauses as described in Paragraph 022.01.a., 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. ( )

02. Waivers. 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. ( )

03. Duplicate Benefits. No Medicare supplement policy or certificate in force in this state may contain benefits which duplicate benefits provided by Medicare. ( )

013. -- 021. (RESERVED)

022. BENEFIT STANDARDS FOR 2010 STANDARDIZED 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 benefit plan for sale on or after June 1, 2010. Benefit standards applicable to policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain in effect. ( )

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation. ( )

a. A Medicare supplement policy or certificate cannot 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 will 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. ( )

b. A Medicare supplement policy or certificate will not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. ( )

c. A Medicare supplement policy or certificate provides 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.( )

d. No Medicare supplement policy or certificate may 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. ( )

e. Each Medicare supplement policy is guaranteed renewable. ( )

i. The issuer cannot cancel or nonrenew the policy solely on the ground of health status of the individual. ( )

ii. The issuer cannot cancel or nonrenew the policy for any reasons other than nonpayment of premium or material representation. ( )

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 022.01.e.v., the issuer offers certificateholders an individual Medicare supplement policy which (at the option of the certificateholder): ( )

(1) Provides for continuation of the benefits contained in the group policy; or ( )

(2) Provides for benefits that meet the requirements of this Subsection. ( )

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer: ( )

(1) Offers the certificateholder the conversion opportunity described in Subparagraph 022.01.e.iii.; or ( )

(2) At the option of the group policyholder, offers the certificate holder continuation of coverage under the group policy. ( )

v. 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 offers coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy cannot exclude preexisting conditions that would have been covered under the group policy being replaced. ( )

f. Terminations of a Medicare supplement policy or certificate need to be without prejudice to any continuous loss that commenced while the policy was in force. Such 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. ( )

g. A Medicare supplement policy or certificate provides that benefits and premiums under the policy or certificate may 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. ( )

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate is automatically reinstituted (effective as of the date of termination of entitlement) 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. ( )

ii. Each Medicare supplement policy provides that benefits and premiums under the policy may 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 is automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within (90) days after the date of the loss and pays the premium attributed to the period, effective as of the date of termination of enrollment in the group health plan. ( )

iii. Reinstitution of coverages as described in Subparagraphs 022.01.g.i. and 022.01.g.ii.; ( )

(1) Does not provide for any waiting period with respect to treatment of preexisting conditions; ( )

(2) Provides for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and ( )

(3) Provides 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. ( )

h. An issuer makes available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02. ( )

i. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 022.04.h. and 022.04.i.), then the issuer makes 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 Paragraph 022.01.h., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 022.04.c.) or standardized benefit Plan F (as described in Paragraph 022.04.e.). ( )

j. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section are offered for sale in this state, except as may be permitted in Subsection 022.05 and in Section 031. ( )

k. Benefit plans are uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010. Each benefit is structured in accordance with the format provided in Subsections 022.02 and 022.03; or, in the case of plans K or L, in Paragraphs 022.04.h. and 022.04.i. and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of benefit. ( )

l. In addition to the benefit plan designations prescribed in Paragraph 022.01.k., an issuer may use other designations to the extent permitted by law. ( )

02. 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 makes 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. ( )

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period; ( )

b. 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; ( )

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 three hundred sixty-five (365) days. The provider will accept the issuer's payment as payment in full and will not bill the insured for any balance; ( )

d. 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; ( )

e. 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; ( )

f. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses. ( )

03. Standards for Additional Benefits. The following additional benefits are included in Medicare

supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 024. ( )

a. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period. ( )

b. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period. ( )

c. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. ( )

d. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. ( )

e. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all 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. ( )

f. 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 two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset. ( )

04. Make-up of 2010 Standardized Benefit Plans. ( )

a. Standardized benefit Plan A includes only the following: The basic (core) benefits as defined in Subsection 022.02. ( )

b. Standardized benefit Plan B includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Paragraph 022.03.a. ( )

c. Standardized benefit Plan C includes only the following: The basic (core) benefit as defined in Subsection 022.02, 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 Paragraphs 022.03.a., 022.03.c., 022.03.d., and 022.03.f., respectively. ( )

d. Standardized benefit Plan D includes only the following: The basic (core) benefit (as defined in Subsection 022.02), 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 Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively. ( )

e. Standardized [regular] Plan F includes only the following: The basic (core) benefit as defined in Subsection 022.02, 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 Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively. ( )

f. Standardized Plan F with High Deductible includes only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 022.04.f.ii. ( )

i. The basic (core) benefit as defined in Subsection 022.02, 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 Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively. ( )

ii. The annual deductible in Plan F with High Deductible consists of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and is in addition to any other specific benefit deductibles. The basis for the deductible is one thousand five hundred dollars ($1,500) and is adjusted annually from 1999 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 ten dollars ($10). ( )

g. Standardized benefit Plan G includes only the following: The basic (core) benefit as defined in Subsection 022.02, 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 Paragraphs 022.03.a., 022.03.c., 022.03.e., and 022.03.f., respectively. Effective January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020. ( )

h. Standardized Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following: ( )

i. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period. ( )

ii. Part A Hospital Coinsurance ninety-first through one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period; ( )

iii. Part A Hospitalization After One Hundred Fiftieth Day: 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 three hundred sixty-five (365) days. The provider accepts the issuer's payment as payment in full and will not bill the insured for any balance; ( )

iv. 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 022.04.h.x. ( )

v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth 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 022.04.h.x. ( )

vi. 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 022.04.h.x. ( )

vii. 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 022.04.h.x. ( )

viii. Part B Cost Sharing: Except for coverage provided in Subparagraph 022.04.h.ix., 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 022.04.h.x. ( )

ix. 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 ( )

x. 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 four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary. ( )

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following: ( )

i. The benefits described in Subparagraphs 022.04.h.i. through 022.04.h.iii., and 022.04.h.ix. ( )

ii. The benefits described in Subparagraphs 022.04.h.iv. through 022.04.h.viii. but substituting seventy-five percent (75%) for fifty percent (50%); and ( )

iii. The benefit described in Subparagraph 022.04.h.x. but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000). ( )

j. Standardized Medicare supplement Plan M includes only the following: The basic (core) benefit as defined in Subsection 022.02, 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 Paragraphs 022.03.b., 022.03.c., and 022.03.f., respectively. ( )

k. Standardized Medicare supplement Plan N includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively, with copayments in the following amounts: ( )

i. 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 ( )

ii. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment is waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. ( )

05. 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 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 cannot adversely impact the goal of Medicare supplement simplification. New or innovative benefits cannot include an outpatient prescription drug benefit. New or innovative benefits cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. ( )

023. -- 024. (RESERVED)

025. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED 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 need to 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 Section 022. ( )

01. Benefit Requirements. The standards and requirements of Section 024 apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions: ( )

a. Standardized benefit Plan C is redesignated as Plan D and provides the benefits contained in Paragraph 022.04.c. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. ( )

b. Standardized benefit Plan F is redesignated as Plan G and provides the benefits contained in Paragraph 022.04.e. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. ( )

c. Standardized benefit plans C, F, and F with High Deductible will not be offered to individuals newly eligible for Medicare on or after January 1, 2020. ( )

d. Standardized benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and provides the benefits contained in Paragraph 022.04.f., but will 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 is considered an out-of-pocket expense in meeting the annual high deductible. ( )

e. The reference to Plans C or F contained in Paragraph 022.01.i. is deemed a reference to Plans D or G for purposes of this section. ( )

02. Applicability to Certain Individuals. This section applies only to individuals that are newly eligible for Medicare on or after January 1, 2020: ( )

a. By reason of attaining age sixty-five (65) on or after January 1, 2020; or ( )

b. 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 eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020. ( )

03. Guaranteed Issue for Eligible Persons. For purposes of Subsection 041.05, 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) is deemed a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of Subsection 025.01. ( )

04. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection 022.04. ( )

026. -- 035. (RESERVED)

036. OPEN ENROLLMENT.

01. Offer of Coverage. ( )

a. An issuer cannot 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: ( )

i. The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. ( )

ii. The first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or ( )

iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration. ( )

b. Each Medicare supplement policy and certificate currently available from an issuer is made available to all applicants who qualify under Paragraph 036.01.a. without regard to age. ( )

02. Treatment of Preexisting Conditions. ( )

a. If an applicant qualifies under Subsection 036.01 and applies during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer cannot exclude benefits based on a preexisting condition. ( )

b. If the applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer reduces 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 specifies the manner of the reduction under this Subsection. ( )

c. Except as provided in Paragraphs 036.02.a. and 02.b., and Sections 041 and 081, nothing in this chapter prevents 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 diagnosed during the six (6) months before the coverage became effective. ( )

037. -- 040. (RESERVED)

041. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue. ( )

a. Eligible persons are those individuals described in Subsection 041.02 who seek to enroll under the policy during the period specified in Subsection 041.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy. ( )

b. With respect to eligible persons, an issuer cannot deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 041.05 that is offered and is available for issuance to new enrollees by the issuer, cannot discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and will not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. ( )

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 041.02: ( )

a. 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; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; ( )

b. 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 sixty-five (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: ( )

i. The certification of the organization or plan under this part has been terminated; ( )

ii. The organization has terminated or discontinued providing the plan in the area in which the individual resides; ( )

iii. 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; ( )

iv. The individual demonstrates, in accordance with guidelines established by the Secretary: ( )

(a) That 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 ( )

(b) 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 ( )

(c) The individual meets such other exceptional conditions as the Secretary may provide. ( )

c. 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 ( )

d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 041.02.b. ( )

e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: ( )

i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or ( )

ii. Of other involuntary termination of coverage or enrollment under the policy; ( )

iii. The issuer of the policy substantially violated a material provision of the policy; or ( )

iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. ( )

f. 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 ( )

g. The subsequent enrollment under Paragraph 041.02.f. 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); or ( )

h. The individual, upon first becoming eligible for benefits under Part A of Medicare, 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. ( )

i. 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 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 Paragraph 041.05.e. ( )

j. The individual is enrolled in a Medicare Supplement policy, and, on or after March 1, 2022, voluntarily terminates enrollment and enrolls in another Medicare Supplement policy. ( )

03. Guaranteed Issue Time Periods. ( )

a. In the case of an individual described in Paragraph 041.02.a., the guaranteed issue period begins on the later of 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 the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; ( )

b. In the case of an individual described in Paragraphs 041.02.b., 041.02.c., 041.02.f., or 041.02.h., 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; ( )

c. In the case of an individual described in Paragraph 041.02.e., 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; ( )

d. In the case of an individual described in Paragraph 041.02.b. and Subparagraph 041.02.e.iii., and Subparagraph 041.02.e.iv., Paragraph 041.02.f., or 041.02.h., 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; and ( )

e. In the case of an individual described in Paragraph 041.02.i., 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 (60) 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 ( )

f. In the case of an individual described in Subsection 041.02 but not described in the preceding provisions of Subsection 041.03, 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. ( )

g. In the case of an individual described in Paragraph 041.02.j., the guaranteed issue period begins on

the individual's birthday and ends sixty-three (63) days thereafter. ( )

04. Extended Medigap Access for Interrupted Trial Periods. ( )

a. In the case of an individual described in Paragraph 041.02.f. (or so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 041.02.f. 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 is deemed an initial enrollment described in Paragraph 041.02.f.; ( )

b. In the case of an individual described in Paragraph 041.02.h. (or so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph 041.02.h. 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 is deemed an initial enrollment described in Paragraph 041.02.h.; and ( )

c. For purposes of Paragraphs 041.02.f. and 041.02.h., no enrollment of an individual with an organization or provider described in Paragraph 041.02.f. or with a plan or in a program described in Paragraph 041.02.h. may be deemed 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. ( )

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under: ( )

a. Paragraphs 041.02.a. through 041.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. ( )

b. Subject to Paragraph 041.05.c., Paragraph 041.02.g. 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 041.05.a. ( )

c. 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 Subsection 041.05 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; ( )

d. Paragraph 041.02.h. includes any Medicare supplement policy offered by any issuer. ( )

e. Paragraph 041.02.i. 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. Paragraph 041.02.j. includes any comparable or lesser Medicare policy offered by any issuer. For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Supplement policy or certificate being replaced. ( )

06. Notification Provisions. ( )

a. At the time of an event described in Subsection 041.02 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, notifies the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated contemporaneously with the notification of termination. ( )

b. At the time of an event described in Subsection 041.02 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, notifies the individual of the individual's rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated within ten (10) working days of the issuer receiving notification of disenrollment. ( )

042. -- 045. (RESERVED)

046. STANDARDS FOR CLAIMS PAYMENT.

01. Compliance. An issuer will 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: ( )

a. 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 needed and making a payment determination on the basis of the information contained in that notice; ( )

b. Notifying the participating physician or supplier and the beneficiary of the payment determination; ( )

c. Paying the participating physician or supplier directly; ( )

d. 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; ( )

e. Paying user fees for claim notices; and ( )

f. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers. ( )

02. Certification. Compliance with the requirements set forth in Subsection 046.01 is certified on the Medicare supplement insurance experience reporting form. ( )

047. -- 050. (RESERVED)

051. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards. ( )

a. A Medicare supplement policy form or certificate form will 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 managed care 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 managed care organization will 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. ( )

c. All filings of rates and rating schedules 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 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. Demonstrations, at a minimum, account for: ( )

i. Lapse rates; ( )

ii. Medical trend and rationale for trend; ( )

iii. Assumptions regarding future premium rate revisions; and ( )

iv. Interest rates for discounting and accumulating. ( )

d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are individual policies. ( )

02. Refund or Credit Calculation. ( )

a. An issuer collects and files with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible on the Department website for each type in a standard Medicare supplement benefit plan. ( )

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is needed. The refund calculation is 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 is excluded. ( )

c. For policies or certificates issued prior to July 1, 1992, the issuer makes 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 July 1, 1992. ( )

d. A refund or credit is made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund includes interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due is made by

September 30 following the experience year upon which the refund or credit is based. ( )

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates in this state annually files 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 demonstrates 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 excludes active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage is 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 files with the director, in accordance with the applicable filing procedures of this state: ( )

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents accompanying the filing need to justify the adjustment. ( )

i. An issuer's adjustments need to produce an expected loss ratio under the policy or certificate that conforms 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 is made with respect to a policy at any time other than upon its renewal date or anniversary date. ( )

ii. 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 prescribed by Section 051. ( )

b. 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 provides a clear description of the Medicare supplement benefits provided by the policy or certificate. ( )

052. -- 055. (RESERVED)

056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Filing of Policy Forms. ( )

a. An issuer cannot 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 would file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as prescribed 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. ( )

02. Filing of Premium Rates. ( )

a. An issuer cannot 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. ( )

b. Except as provided in Subsection 051.03, the insured cannot receive more than one (1) rate increase in any twelve (12) month period. ( )

03. Except as provided in Paragraph 056.03.a., an issuer will not file for approval more than one (1)

form of a policy or certificate of each type for each standard Medicare supplement benefit plan. ( )

a. An issuer may offer, with the approval of the director, up to three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases: ( )

i. The inclusion of new or innovative benefits; ( )

ii. The addition of either direct response or agent marketing methods; ( )

iii. The addition of either guaranteed issue or underwritten coverage; ( )

b. For the purposes of Section 056, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. ( )

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 056.04.a., an issuer continuously makes available for purchase any policy form or certificate form. A policy form or certificate form would not be considered available for purchase unless the issuer has actively offered it for sale continuously during 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 this notice by the director, the issuer no longer offers 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 Paragraph 056.04.a. will 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. ( )

c. The sale or other transfer of Medicare supplement business to another issuer is considered a discontinuance for the purposes of Subsection 056.04. ( )

d. A change in the rating structure or methodology is considered a discontinuance under this Subsection 056.04 unless the issuer complies with the following requirements: ( )

i. 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. ( )

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest. ( )

05. Experience of Policy Forms. ( )

a. Except as provided in Paragraph 056.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan is combined for purposes of the refund or credit calculation prescribed in Section 051. ( )

b. Forms assumed under an assumption reinsurance agreement are not combined with the experience of other forms for purposes of the refund or credit calculation. ( )

c. The experience of all policy forms or certificate forms for standardized benefit plans of the same type is combined for purposes of the rate change filing. Generally, any applicable percentage increase is filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal

lifetime loss ratio standards for specific forms within the same type. ( )

06. Age Rating. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under *this chapter*: *( )*

a. It is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. For issue-age rated policies: ( )

i. For an individual who is sixty-five (65) years of age or older, the filed rate for any given age will not exceed the rate for any higher issue-age, similarly rated individual; and ( )

ii. For an individual who is under sixty-five (65) years of age, the premium is no greater than one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65) similarly rated individual, while the individual's attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) is charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. ( )

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age or issue age of an insured, subscriber or participant as a basis for premiums. For such community-rated policies: ( )

i. For an individual who is eligible for Medicare Part B only due to disability or end stage renal disease, the premium is no greater than one hundred fifty percent (150%) of the premium for an enrollee otherwise eligible for Medicare Part B; and ( )

ii. Upon attaining Medicare Part B eligibility due to age, a policyholder who was previously eligible for Medicare Part B only due to disability or end stage renal disease is to be charged the same premium rate as an individual eligible for Medicare Part B due to age. ( )

07. Rating by Area and Gender. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under *this chapter*, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose. *( )*

08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, sold to residents of this State on or after January 1, 2018: ( )

a. Any rate adjustments are uniform between 1990 Standardized and later Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. ( )

b. The rating by the issuer does not differentiate on the basis of the reason for eligibility for Medicare Part B, except for an individual, at any given age, described at Subparagraph 056.06.b.i. ( )

09. Discriminatory Discount or Other Payment Practices. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under *this chapter*: *( )*

a. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 036, or guaranteed issue, per Section 041, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue. ( )

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer to require application *or policy* fees or to vary premium rates based on payment terms including, without limitation, payment method or frequency of payment. *( )*

c. Nothing in this Subsection is construed to limit the ability of an issuer of a Medicare supplement policy or certificate to *apply* a discount *or underwriting factor* for: *( )*

i. Multiple Medicare Supplement policies issued to individuals residing within the same household, or; ( )

ii. Non-smoking or non-tobacco use. ( )

057. -- 060. (RESERVED)

061. PERMITTED COMPENSATION ARRANGEMENTS.

01. Commissions. 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 two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. An issuer or other entity may not vary commission or otherwise pay commission differentials based upon variables such as age, guarantee issue status, or on any other basis. ( )

02. Compensation in Subsequent Years. The commission or other compensation provided in subsequent renewal years needs to be the same as that provided in the second year or period and be provided for no fewer than five (5) renewal years. ( )

03. Renewal Compensation. No issuer or other entity provides compensation to its agent or other producers and no agent or producer receives compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced. ( )

04. Compensation. For purposes of Section 061, 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 finder's fees. ( )

062. -- 065. (RESERVED)

066. DISCLOSURE PROVISIONS.

01. General Rules. ( )

a. Medicare supplement policies and certificates includes a renewal or continuation provision. The language or specifications of the provision is consistent with the type of contract issued. The provision is appropriately captioned and appears on the first page of the policy, and includes any reservation by the issuer of the right to change premiums. ( )

b. 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 needed 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 requires 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 is agreed to in writing and signed by the insured, unless the benefits are prescribed by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy. ( )

c. Medicare supplement policies or certificates do not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import. ( )

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations." ( )

e. Medicare supplement policies and certificates 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 has 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. ( )

f. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed jointly by the National Association of Insurance Commissions and the Centers for Medicare & Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide is made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates. Except in the case of direct response issuers, delivery of the Guide will be made to the applicant at the time of application and acknowledgment of receipt of the Guide is obtained by the issuer. Direct response issuers deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. ( )

g. For the purposes of Section 066, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing. ( )

02. Notice Requirements. ( )

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer notifies 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 will: ( )

i. 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 ( )

ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare. ( )

b. The notice of benefit modifications and any premium adjustments is in outline form and in clear and simple terms so as to facilitate comprehension. ( )

c. The notices cannot contain or be accompanied by any solicitation. ( )

03. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Notice Requirements. Issuers comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. ( )

04. Outline of Coverage Requirements for Medicare Supplement Policies. ( )

a. Issuers provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, obtain an acknowledgment of receipt of the outline from the applicant; and ( )

b. 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 accompanies the policy or certificate when it is delivered and contains 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." ( )

c. The outline of coverage provided to applicants pursuant to this section consists of four (4) 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 is in the language and format prescribed below in no less than twelve (12) point type. All plans are shown on the cover page, and the plans that are offered by the issuer are prominently identified.

Premium information for plans that are offered are shown on the cover page or immediately following the cover page and is prominently displayed. The premium and mode is stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant are illustrated. ( )

05. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies. ( )

a. Any accident and sickness insurance policy or certificate other than Medicare supplement policy and 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 Paragraph 001.02.b., issued for delivery in this state to persons eligible for Medicare notifies insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice is either 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 is no less than twelve (12) point type and contains 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." ( )

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph 066.04.a. disclose, using the applicable NAIC Model Regulation as incorporated by reference in Section 002 and referenced as Appendix C. The disclosure statement is provided as a part of, or together with, the application for the policy or certificate. ( )

067. -- 070. (RESERVED)

071. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another 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. ( )

02. Statements. ( )

a. You do not need more than one (1) Medicare supplement policy. ( )

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. ( )

c. You may be eligible for benefits under Medicaid and not need a Medicare supplement policy. ( )

d. 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 twenty-four (24) months. You need to request this suspension within ninety (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 ninety (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. ( )

e. 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 ninety (90) days of losing your employer or union-based 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. ( )

f. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), 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). ( )

03. Agents. Agents will list any other health insurance policies they have sold to the applicant. ( )

a. List policies sold which are still in force. ( )

b. List policies sold in the past five (5) years which are no longer in force. ( )

04. Direct Response Issuer. 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, is returned to the applicant by the insurer upon delivery of the policy. ( )

05. Notice Regarding Replacement of Medicare Supplement Coverage. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, furnishes the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, is provided to the applicant and an additional signed copy is retained by the issuer. A direct response issuer delivers to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage. ( )

06. SHIBA and Consumer Assistance Link. The notice prescribed in Subsection 071.05 for an issuer is provided in the NAIC Model Regulation as incorporated by reference in Section 002 of this rule, which includes NAIC Appendixes A, B, and C and all other outlines of coverage and specific plan designs which can be accessed on the Idaho Department of Insurance website. To obtain a copy of the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance. ( )

072. FILING REQUIREMENTS FOR ADVERTISING.

An issuer provides a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by the director. ( )

073. STANDARDS FOR MARKETING.

01. Issuer. An issuer, directly or through its producers: ( )

a. Establishes marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. ( )

b. Establishes marketing procedures to assure excessive insurance is not sold or issued. ( )

c. Displays 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."** ( )

d. Inquires and makes 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. ( )

e. Establishes auditable procedures for verifying compliance with this Subsection 073.01. ( )

02. Banned Acts and Practices. In addition to the practices banned in Title 41, Chapter 13,Idaho Code, the following acts and practices are banned: ( )

a. 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. ( )

b. 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. ( )

03. Banned Terms. The terms "Medicare supplement," "Medigap," "Medicare wrap-around," and words of similar import cannot be used unless the policy is issued in compliance with this chapter. ( )

074. -- 075. (RESERVED)

076. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.
In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent makes reasonable efforts to determine the appropriateness of a recommended purchase or replacement. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is banned. An issuer cannot 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. ( )

077. REPORTING OF MULTIPLE POLICIES.

01. Reporting. On or before March 1 of each year, an issuer reports the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate: ( )

a. Policy and certificate number, and ( )

b. Date of issuance. ( )

02. Grouping by Individual Policyholder. The items set forth above need to be grouped by individual policyholder. ( )

078. -- 080. (RESERVED)

081. PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

01. Waiving of Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer waives any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy. ( )

02. Replacing Policy. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at last six (6) months, the replacing policy does not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. ( )

082. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.

01. Banned Provisions. An issuer of a Medicare supplement policy or certificate: ( )

a. Does not deny or condition the issuance of 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 ( )

b. Does 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. ( )

02. Denial of Coverage. Nothing in Subsection 082.01 is construed to limit the ability of an issuer, to the extent otherwise permitted by law, from: ( )

a. 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 ( )

b. 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 will not also be used as genetic information about other group members and to further increase the premium for the group). ( )

03. Genetic Testing. An issuer of a Medicare supplement policy or certificate cannot request or require an individual or a family member of such individual to undergo a genetic test. ( )

04. Payment. Subsection 082.03 does not 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 082.01. ( )

05. Information. For purposes of carrying out Subsection 082.04, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose. ( )

06. Allowed Genetic Testing. Notwithstanding Subsection 082.03, 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: ( )

a. 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 rules for the protection of human subjects in research. ( )

b. 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: ( )

i. Compliance with the request is voluntary; and ( )

ii. Non-compliance will have no effect on enrollment status or premium or contribution amounts. ( )

c. No genetic information collected or acquired under Subsection 082.06 is 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. ( )

d. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under Subsection 082.06, including a description of the activities conducted. ( )

e. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under Subsection 082.06. ( )

f. An issuer of a Medicare supplement policy or certificate cannot request, require, or purchase genetic information for underwriting purposes. ( )

g. An issuer of a Medicare supplement policy or certificate cannot 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. ( )

h. If an issuer of Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, such request, requirement, or purchase is not considered a violation of Paragraph 082.06.g. if such request, requirement, or purchase is not in violation of Paragraph 082.06.f. ( )

07. Definitions. For the purposes of this section only; ( )

a. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer. ( )

b. "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. ( )

c. "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. ( )

d. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education. ( )

e. "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. ( )

f. "Underwriting purposes" means: ( )

i. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy; ( )

ii. The computation of premium or contribution amounts under the policy; ( )

iii. The application of any preexisting condition exclusion under the policy; and ( )

iv. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. ( )

083. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.06.04 – CONTINUING EDUCATION

DOCKET NO. 18-0604-2101 (NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 41-211, 41-1025, and 41- 5820, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule prescribes minimum education in approved subjects that a licensee must periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 61-66.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211, 41-1025, and 41-5820, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, September 20, 2021 @ 2:00 p.m. (MT)

700 W State Street
3rd Floor
Boise, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule prescribes minimum education in approved subjects that a licensee must periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 56-57 under docket 18-ZBRR-2101.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2021.

DATED this July 29, 2021.

THE FOLLOWING IS THE TEXT OF PENDING DOCKET NO. 18-0604-2101

18.06.04 – CONTINUING EDUCATION

000. LEGAL AUTHORITY.
Title 41, Chapters 2, 10, 11, and 58, Sections 41-211, 41-1013, 41-1108, 41-5813, and 41-5820, Idaho Code. ( )

001. SCOPE.
This rule prescribes a minimum education in approved subjects that impacts all resident licensees practicing insurance, except for producers licensed to sell only "limited lines insurance," and requires them to periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Licensee. An individual holding a license as a producer, bail, adjuster, or public adjuster pursuant to Title 41, Chapters 10, 11, or 58, Idaho Code. ( )

011. (RESERVED)

012. BASIC REQUIREMENTS.

01. Proof of Completion. As a condition for the continuation of a license, a licensee must complete a total of 24 hours of continuing education credits, including a minimum of 3 ethics credits on or before the licensing renewal date every two (2) years. Proof of satisfactory completion of approved subjects or courses will be downloaded to licensing records by the system vendor in a format acceptable to the Director. ( )

a. No more than four (4) hours of continuing education credit from courses approved for adjusters or public adjusters can apply toward the continuation of a producer license. ( )

02. Completion Within Two Years. Each course to be applied toward satisfaction of the continuing education requirement is to be completed within the two (2) year period immediately preceding renewal of the license. Courses cannot have been duplicated in the same renewal period. The date of completion for a self-study course is the date of successful completion of exam. ( )

013. EXCEPTIONS/EXTENSIONS.

01. Exceptions and Extensions. The following exceptions and extensions may be made to the continuing education rules: ( )

a. Licensees on extended active duty with the Armed Forces of the United States for the period of such duty and all other exceptions allowed under Section 41-1008(4), Idaho Code. ( )

b. Persons which hold a temporary license as provided in Section 41-1015, Idaho Code. ( )

c. The Continuing Education Advisory Committee or the Director may approve an exception or extension for an extra ordinary situation that is requested by a licensee, in writing, setting forth the basis for the exception or extension. and received prior to the renewal date by the Director or Committee. ( )

014. CONTINUING EDUCATION ADVISORY COMMITTEE.

01. Continuing Education Advisory Committee. An eleven (11) member Continuing Education Advisory Committee ("Committee") comprised of representatives from each segment of the insurance industry, is appointed by the Director. Committee members will serve a term of three (3) years. ( )

02. Duties of the Committee. The Committee performs the following duties at the discretion of the Director: ( )

a. Approve or disapprove courses as per the standards of this rule and assign the number of continuing education hours to be awarded. ( )

b. Consider applications for exceptions and extensions as permitted under Section 013; and ( )

c. Consider other matters as the Director may assign. ( )

03. Quorum. Those present at any meeting of the Committee are a quorum for purposes of acting to perform the duties of the Committee pursuant to this rule. Matters before the Committee may be decided by a majority of those members present. In the event of a tie vote, the Chairman votes to break the tie. ( )

015. PROGRAM REQUIREMENTS.

All continuing education programs need to be submitted to the Committee in accordance with Section 021 on forms promulgated by the Director. Any course provider that resides in and has had their continuing education program(s) approved by, a state in which the insurance department has signed a separate reciprocity agreement with the Idaho Department, need not have their continuing education program(s) reviewed and approved by the Committee. However, all such courses need to be filed with the Department in a format approved by the Director and course application fees paid. ( )

016. PROGRAMS WHICH QUALIFY.

01. Requirements of Acceptable Program. A specific program will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each individual licensee to determine the course of study to be pursued. All programs need to meet the standards outlined in Section 018. ( )

02. Subjects Which Qualify. ( )

a. The following general subjects are acceptable for producers. ( )

i. Insurance, fixed and indexed annuities, and risk management. ( )

ii. Insurance laws and rules. ( )

iii. Mathematics, statistics, and probability. ( )

iv. Economics. ( )

v. Business law. ( )

vi. Finance. ( )

vii. Taxes, trusts, estate planning. ( )

viii. Business environment, management, or organization. ( )

ix. Securities. ( )

b. The following general subjects are acceptable for adjusters and public adjusters. ( )

i. Insurance. ( )

ii. Insurance laws and rules. ( )

iii. Mathematics, statistics, and probability. ( )

iv. Economics. ( )

v. Business law. ( )

vi. Restoration. ( )

vii. Communications. ( )

viii. Arbitration. ( )

ix. Mitigation. ( )

x. Glass replacement and/or repair. ( )

c. Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to professional competence and meet the standards set forth in this rule. The responsibility for substantiating that a particular program meets the requirements of this rule rests solely upon the licensee. ( )

017. PROGRAMS WHICH DO NOT QUALIFY.

01. Any Course Used to Prepare for Taking an Insurance Licensing Examination. ( )

02. Committee Service of Professional Organizations. ( )

03. Computer Science Courses. ( )

04. Motivation, Psychology, or Selling Skills Courses. ( )

05. Reviews, Quizzes and/or Examinations. ( )

06. Any Program Not in Accordance with This Rule. ( )

018. STANDARDS FOR CONTINUING EDUCATION PROGRAMS.
To qualify for credit, the following standards need to be met by all continuing education programs: ( )

01. Program Development. ( )

a. The program provides significant intellectual or practical content to enhance and improve the insurance knowledge and professional competence of participants. ( )

b. The program is developed by persons who are qualified in the subject matter and instructional design. ( )

c. The program content is current or up to date. ( )

02. Program Presentation. ( )

a. Instructors are qualified, both with respect to program content and teaching methods. Instructors will be considered qualified if, through formal training or experience, they have obtained sufficient knowledge to instruct the course competently. ( )

b. The number of participants and physical facilities is consistent with the teaching method specified. ( )

c. All programs will include some means for evaluating quality. ( )

019. MEASUREMENT OF CREDIT.

01. Credits Measured in Full Hours. Professional education courses are credited for continuing education purposes in full hours only. The number of hours is equivalent to the actual number of contact hours which need to include at least fifty (50) minutes of instruction or participation. No credit will be given for partial attendance. ( )

02. Internet Courses. Internet self-study courses will be credited one (1) hour of continuing education for every fifty (50) minutes of study material, excluding exams. Credit will be given in accordance with Section 021. ( )

03. Webinar Courses. Webinars will be credited as classroom instruction or participation. In the event one (1) course encompasses multiple webinars and self-study is necessary between webinars, the self-study material need to be submitted to the Committee to be evaluated for additional credit in accordance with Section 021. ( )

020. CONTROLS AND REPORTING.

01. Licensee to Retain Original Certificate as Evidence. The original certificate of completion received for each educational program or course is retained by the licensee to evidence completion during the two (2) year renewal period. The certificate of completion is in a format provided to the Department. ( )

02. Sign-In and Sign-Out Sheets. Sign-in and sign-out sheets are to be used and monitored to ensure attendance for the full length of the seminar. No certificate of completion is to be given to anyone arriving late or leaving prior to the conclusion of the seminar. Failure to comply with these requirements will result in loss of certification of the provider in accordance with Section 023. ( )

021. APPROVED PROGRAMS OF STUDY - CERTIFICATION BY DIRECTOR.

01. Requirements of Course Approval. All courses are approved by the Committee. If a course is not approved in advance of presentation, an application for credit may be submitted to the Committee within sixty (60) days of completion of the course. ( )

02. Nonrefundable Application Fee. Each course application is accompanied by a nonrefundable application fee (as set forth in IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges"). ( )

03. Course Approval Procedures. Any person intending to provide courses applies in a format prescribed by the Department and provides the following supporting documentation: ( )

a. A specific outline and/or course material; ( )

b. Time schedule; ( )

c. Method of presentation; ( )

d. Qualifications of instructor; and ( )

e. Other information supporting the request for approval. ( )

04. Method to Determine Completion. The submission includes a statement of the method used to determine the satisfactory completion of the course. Methods may be an examination, or certification by the provider of the agent's program attendance or completion, or other methods approved by the Director. ( )

05. Certification of Program. Certification of a program is effective for two (2) years or until any material changes are made in the program, after which it may be resubmitted to the Committee for approval. ( )

022. PROOF OF COMPLETION.
An authorized representative of the sponsoring organization will, within thirty (30) days of completion of the course, provide a certificate of completion to each individual who satisfactorily completed the course and certify to the Department electronically a list of all such individuals. ( )

023. APPROVED SUBJECTS - LOSS OF CERTIFICATION.

01. Program Suspension. The certification of a program may be suspended by the Director if it has been determined that: ( )

a. The program teaching method or program content no longer meets the standards of this rule, or have been significantly changed without notice to the Director for recertification; ( )

b. The program certified to the Director that an individual completed the program, when in fact the individual had not done so; ( )

c. Individuals who have satisfactorily completed the program of study were not so certified by the program; ( )

d. The instructor or sponsoring organization is not qualified per the standards of this rule or lacks education or experience in the subject matter of the proposed course; ( )

e. The instructor, sponsoring organization, or any company or affiliate of a sponsoring organization has had a license revoked or suspended in any jurisdiction. This includes any firm or organization where a revoked or suspended individual has a substantial ownership interest, or other control in a firm or organization; or ( )

f. There is other good and just cause why certification should be suspended. ( )

02. Reinstatement of a Suspended Certification. Reinstatement of a suspended certification will be made upon proof satisfactory to the Committee or the Director, that the conditions responsible for the suspension have been corrected. ( )

024. CREDIT FOR INDIVIDUAL STUDY PROGRAMS.

01. Requirements for Credit of Independent Study Programs. All approved correspondence courses or independent study programs needs to include an examination which requires a score of seventy percent (70%) or better to earn a certificate of completion. For each approved course, the sponsoring organization will maintain multiple tests (two (2) or more) sufficient to maintain the integrity of the testing process. A written explanation of test security and administration methods will accompany the course examination materials. Each unit and/or chapter of a course will contain review questions that can be answered with a score of seventy percent (70%) or better before access to the following unit/chapter is allowed. ( )

02. Completed Tests. The examinations are administered, graded, and the results recorded by the organization to which approval was originally granted. Completed tests are retained by the sponsoring organization and will not be returned to any licensee. ( )

03. Prior Approval Needed for Correspondence Courses. All correspondence courses need be submitted for approval and approved prior to being offered to licensees for continuing education credit. ( )

025. CREDIT FOR SERVICE AS LECTURER, DISCUSSION LEADER, OR SPEAKER.
Only one (l) hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader. ( )

026. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

DOCKET NO. 24-0000-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or date specified in, the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code, and the following additional sections of Idaho Code:

IDAPA **24.33** – Sections 54-1806(1), 54-5105, 54-3913, 54-4305, and 54-3505, Idaho Code;
IDAPA **24.39 –** Sections 39-4113, 39-8007, 44-2102, 44-2104, and 67-2605, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 24, rules of the Division of Occupational and Professional Licenses:

IDAPA 24
- 24.33.03, *General Provisions of the Board of Medicine*;
- 24.39.60, *Rules Governing Uniform School Building Safety*; and
- 24.39.80, *Idaho Minimum Safety Standards and Practices for Logging*.

There are no changes to the pending rule and it has been adopted as originally proposed. The complete text of the proposed rulemaking was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, Vol. 21-10SE, pages 3280-3354.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Tim Frost at (208) 577-2491 or tim.frost@dopl.idaho.gov.

Dated this 22nd day of December, 2021.

Tim Frost, Deputy Administrator
Division of Occupational & Professional Licenses
Phone: (208) 577-2491
11351 W. Chinden Boulevard, Building #6
Boise, ID 83714
P.O. Box 83720
Boise, ID 83720-0063
tim.frost@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code, and the following additional sections of Idaho Code:.

IDAPA **24.33** – Sections 54-1806(1), 54-5105, 54-3913, 54-4305, and 54-3505, Idaho Code;
IDAPA **24.39 –** Sections 39-4113, 39-8007, 44-2102, 44-2104, and 67-2605, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, November 10, 2021 – 9:00-10:30 a.m. (MT)

Division of Occupational and Professional Licenses
Chinden Campus Building 6 – Idaho Room
11351 W. Chinden Blvd., Bldg. #6
Boise, ID 83714

Rule Chapters for the Building, Construction, Real Estate Bureau: 9:00am-9:30am
Rule Chapters for the Occupational Licenses Bureau: 9:30am-10:00am
Rule Chapters for the Health Professions Bureau: 10:00am-10:30am

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 24, rules of the Division of Occupational and Professional Licenses:

IDAPA 24
- 24.33.03, *General Provisions of the Board of Medicine*;
- 24.39.60, *Rules Governing Uniform School Building Safety*; and
- 24.39.80, *Idaho Minimum Safety Standards and Practices for Logging*.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule(s), contact Tim Frost at (208) 577-2491 or tim.frost@dopl.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 24-0000-2100

000. LEGAL AUTHORITY.
The rules are promulgated pursuant to Section 54-1806(2), Idaho Code. ( )

001. SCOPE.
The rules govern general aspects of Board of Medicine operations. ( )

002. -- 099. (RESERVED)

100. GENERAL QUALIFICATIONS FOR LICENSURE.

01. Application. All applications for license or permit will be made to the Board on forms supplied by the Board, will be verified, must include all requested information, and must include the nonrefundable application fee. ( )

02. Application Expiration. All applicants must complete their license application within one (1) year unless extended by the Board after filing an application for extension. Unless extended, applications that remain on file for more than one (1) year will be considered null and void and a new application and new fees will be required as if filing for the first time. ( )

03. Personal Interview. The Board may, at its discretion, require the applicant to appear for a personal interview. ( )

04. Residence. No period of residence in Idaho is required of any applicant, however, each applicant for licensure must be legally able to work and live in the United States. Original documentation of lawful presence in the United States must be provided upon request only. The Board may refuse licensure or to renew a license if the applicant is not lawfully present in the United States. ( )

101. LICENSE OR PERMIT EXPIRATION AND RENEWAL.

01. License Expiration. Licenses and permits will be issued for a period of not more than five (5) years. All licenses expire on the expiration date printed on the face of the certificate and become invalid after that date unless renewed. The Board will collect a fee for each renewal year of a license. Prorated fees may be assessed by the Board to bring the expiration date of the license within the next occurring license renewal period. ( )

02. Renewal. Each license to practice medicine may be renewed prior to its expiration date by the payment of a renewal fee to the Board and by completion of a renewal form provided by the Board. In order to be eligible for renewal, a licensee must provide a current address and e-mail address to the Board and must notify the Board of any change of address or e-mail address prior to the renewal period. Licenses not renewed by their expiration date will be canceled. ( )

03. Reinstatement. Licenses canceled for nonpayment of renewal fees may be reinstated by filing a reinstatement application on forms prescribed by the Board and upon payment of a reinstatement fee and applicable renewal fees for the period the license was lapsed. ( )

04. Reapplication. A person whose license has been canceled for a period of more than five (5) years, is required to make application to the Board as a new applicant for licensure. ( )

102. LICENSE BY ENDORSEMENT.
Where permitted by law, an applicant, in good standing with no restrictions upon or actions taken against their license to practice in a state, territory or district of the United States or Canada is eligible for licensure by endorsement to practice medicine in Idaho. An applicant with any disciplinary action, including past, pending, or confidential, by any board of medicine, licensing authority, medical society, professional society, hospital, medical school or institution staff in any state, territory, district or country is not eligible for licensure by endorsement. An applicant ineligible for licensure by endorsement may make a full and complete application pursuant to the requirements found in Title 54, Idaho Code, IDAPA 24.33.03, and on Board-approved forms. ( )

01. Application. All applications for license or permit will be made to the Board on forms supplied by the Board, will be verified, must include all requested information, and the nonrefundable application fee. ( )

02. Character. An applicant is not eligible for licensure by endorsement if the Board finds the applicant has engaged in conduct prohibited by state law for that specific category of licensure. ( )

03. Residence. No period of residence in Idaho is required of any applicant, however, each applicant for licensure must be legally able to work and live in the United States. Original documentation of lawful presence in the United States must be provided upon request. The Board may refuse licensure or to renew a license if the applicant is not lawfully present in the United States. ( )

103. (RESERVED)

104. INACTIVE LICENSE

01. Issuance of Inactive License. Any applicant who is eligible to be issued a license by the Board, except a volunteer license, may be issued, upon request, an inactive license to practice on the condition that he will not engage in the practice of the relevant profession in this state. An inactive license fee will be collected by the Board. ( )

02. Renewal of Inactive License. Inactive licenses will be issued for a period of not more than five (5) years and such licenses will be renewed upon payment of an inactive license renewal fee. The inactive license certificate will set forth its date of expiration. ( )

03. Inactive to Active License. An inactive license may be converted to an active license by application to the Board and payment of required fees. Before the license will be converted the applicant must account for the time during which an inactive license was held. The Board may, in its discretion, require a personal interview. ( )

105. -- 149. (RESERVED)

150. ADDITIONAL GROUNDS FOR SUSPENSION, REVOCATION, DISCIPLINARY SANCTIONS OR DENIAL OR RESTRICTION OF A LICENSE.

01. Discipline. In addition to the grounds for discipline set forth in Idaho Code, every person licensed or permitted by the Board is subject to discipline upon any of the following grounds: ( )

02. Unethical Advertising. Advertising the licensee or permittee's practice in any unethical or unprofessional manner, including but not limited to: ( )

a. Using advertising or representations likely to deceive, defraud or harm the public. ( )

b. Making a false or misleading statement regarding the licensee or permittee's skill or the efficacy or value of the treatment, remedy, or service offered, performed, or prescribed by the licensee or permittee. ( )

03. Standard of Care. Providing health care that fails to meet the standard of health care provided by other qualified licensees or permittees of the same profession, in the same community or similar communities, including but not limited to: ( )

a. Being found mentally incompetent or insane by any court of competent jurisdiction. ( )

b. Engaging in practice or behavior that demonstrates a manifest incapacity or incompetence to practice his or her profession. ( )

c. Allowing another person or organization to use his or her license or permit to practice his or her profession. ( )

d. Prescribing, selling, administering, distributing or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug to himself or herself or to a spouse, child or stepchild. ( )

e. Using any controlled substance or alcohol to an extent that use impairs the licensee or permittee's

ability to practice his or her profession competently. ( )

f. Violating any state or federal law or regulation relating to controlled substances. ( )

g. Directly promoting surgical procedures or laboratory tests that are unnecessary and not medically indicated. ( )

h. Failure to transfer pertinent and necessary medical records to another provider when requested to do so by the subject patient or client or by his or her legally designated representative. ( )

i. Failing to maintain adequate records. Adequate patient or client records means legible records that contain, at a minimum, subjective information, an evaluation and report of objective findings, assessment or diagnosis, and the plan of care. ( )

j. Providing care or performing any service outside the licensee or permittee's scope of practice as set forth in Idaho Code, including providing care or performing a service without supervision, if such is required by Idaho Code or Board rule. ( )

k. Failing to have a supervising or directing physician who is licensed by the Board, if such supervision is required by Idaho Code or Board rule. ( )

04. Conduct. Engaging in any conduct that constitutes an abuse or exploitation of a patient or client arising out of the trust and confidence placed in the licensee or permittee by the patient or client, including but not limited to: ( )

a. Obtaining any fee by fraud, deceit or misrepresentation. ( )

b. Employing abusive billing practices. ( )

c. Commission of any act of sexual contact, misconduct, exploitation or intercourse with a patient or client or former patient or client or related to the licensee's practice. ( )

i. Consent of the patient or client shall not be a defense. ( )

ii. This Section 150 does not apply to sexual contact between a licensee or permittee and the licensee or permittee's spouse or a person in a domestic relationship who is also a patient or client. ( )

iii. A former patient or client includes a patient or client for whom the licensee or permittee has provided services related to the licensee or permittee's practice, including prescriptions, within the last twelve (12) months; sexual or romantic relationships with former patients or clients beyond that period of time may also be a violation if the licensee or permittee uses or exploits the trust, knowledge, emotions or influence derived from the prior professional relationship with the patient or client. ( )

d. Accepting any reimbursement for service, beyond actual expenses, while providing services under a volunteer license. ( )

e. Employing, supervising, directing, aiding or abetting a person not licensed or permitted in this state who directly or indirectly performs activities or provides services requiring a license or permit. ( )

f. Failing to report to the Board any known act or omission of a Board licensee or permittee that violates any provision of these rules. ( )

g. Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats or harassment against any patient or client, Board or Advisory Board or Committee member, Board staff, hearing officer, or witness in an attempt to influence the outcome of a disciplinary proceeding, investigation, or other legal action. ( )

h. Failing to obey any and all state and local laws and rules related to the licensee or permittee's practice or profession. ( )

05. Failure to Cooperate. Failing to cooperate with the Board during any investigation or disciplinary proceeding, even if such investigation or disciplinary proceeding does not personally concern the particular licensee. ( )

151. ON SITE REVIEW.
The Board, by and through its designated agents, is authorized to conduct on-site reviews of the activities of its licensees at the locations and facilities in which the licensees practice at such times as the Board deems necessary. ( )

152. – 999. (RESERVED)

000. LEGAL AUTHORITY.
The rules are promulgated pursuant to Section 39-8007, Idaho Code. ( )

001. SCOPE.
The rules prescribe the Idaho Uniform School Building Safety Code and provide for enforcement and administration of the Idaho Uniform School Building Safety Act. ( )

002. INCORPORATION BY REFERENCE.

01. Uniform Codes. The following uniform codes are hereby incorporated by reference into these rules as, and insofar as, the most recent editions have been adopted by the appropriate governing authority for the state of Idaho pursuant to applicable Idaho Code: ( )

a. International Building Code; ( )

b. International Mechanical Code; ( )

c. International Fuel Gas Code; ( )

d. Safety Code for Elevators and Escalators (ASME/ANSI A17.1); ( )

e. International Energy Conservation Code; ( )

f. Accessible and Usable Buildings and Facilities (ICC/ANSI A117.1); ( )

g. Idaho Fire Code (IFC); ( )

h. National Electrical Code (NEC); ( )

i. Idaho State Plumbing Code (UPC); ( )

j. Pacific NW AWWA Manual for Backflow Prevention and Cross Connection Control; and ( )

k. Idaho Safety and Occupational Health Standards. ( )

02. Idaho Uniform School Building Safety Code. The codes set forth in Subsection 002.01 of this rule, together with the definitions contained therein and the written interpretations thereof, insofar as they are applicable to school facilities, constitute the Idaho Uniform School Building Safety Code. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Act. The Idaho Uniform School Building Safety Act. ( )

02. Building Code. The Building Code specified in Paragraph 002.01.a. of these rules. ( )

03. Code. The Idaho Uniform School Building Safety Code. ( )

04. School Building or Building. Any school building, including its structures and appurtenances necessary for the operation of the school building, and subject to the provisions of the Act. ( )

011. -- 049. (RESERVED)

050. VIOLATION OF CODE.

01. Imminent Safety Hazard. Code violations that constitute an imminent safety hazard, include, but are not limited to, whenever the following are observed: ( )

a. Any door, aisle, passageway, stairway or other means of exit is not of sufficient width or size or is

not so arranged as to provide safe and adequate means of exit in case of fire or panic; ( )

b. The walking surface of any aisle, passageway, stairway or other means of exit is so warped, worn, loose, torn or otherwise unsafe as to not provide safe and adequate means of exit in case of fire or panic; ( )

c. The stress in any materials, member or portion thereof, due to all dead and life loads, is more than one and one half (1-1/2) times the working stress or stresses allowed in the Building Code for new buildings of similar structure, purpose or location; ( )

d. Any portion thereof has been damaged by fire, earthquake, wind, flood or by any other cause, to such an extent that the structural strength or stability thereof is materially less than it was before such catastrophe and is less than the minimum requirements of the Building Code for new buildings of similar structure, purpose or location; ( )

e. Any portion or member or appurtenance thereof is likely to fail, or to become detached or dislodged, or to collapse and thereby injure persons or damage property; ( )

f. Any portion of a building, or any member, appurtenance or ornamentation on the exterior thereof is not of sufficient strength or stability, or is not so anchored, attached or fastened in place so as to be capable of resisting a wind pressure of one-half (1/2) of that specified in the Building Code for new buildings of similar structure, purpose or location without exceeding the working stresses permitted in the Building Code for such buildings; ( )

g. Any portion thereof has wracked, warped, buckled or settled to such an extent that walls or other structural portions have materially less resistance to winds or earthquakes than is required in the case of similar new construction; ( )

h. The building or structure, or any portion thereof, because of: ( )

i. Dilapidation, deterioration or decay; ( )

ii. Faulty construction; ( )

iii. The removal, movement or instability of any portion of the ground necessary for the purpose of supporting such building; ( )

iv. The deterioration, decay or inadequacy of its foundation; or ( )

v. Any other cause, is likely to partially or completely collapse; ( )

i. Any building or structure has been constructed, exists or is maintained in violation of any specific requirement or prohibition applicable to such building or structure provided by the building regulations of this jurisdiction, as specified in the Building Code, or of any law or ordinance of this state or jurisdiction relating to the condition, location or structure of buildings; ( )

j. Any building or structure which, whether or not erected in accordance with all applicable laws and ordinances, has in any nonsupporting part, member or portion less than fifty percent (50%), or in any supporting part, member or portion less than sixty-six percent (66%) of the: ( )

i. Strength; ( )

ii. Fire-resisting qualities or characteristics; or ( )

iii. Weather-resisting qualities or characteristics required by law in the case of a newly constructed building of like area, height and occupancy in the same location; ( )

k. Any building or structure, because of obsolescence; dilapidated condition; deterioration; damage;

inadequate exits; lack of sufficient fire-resistive construction; faulty electric wiring, gas connections or heating apparatus; or other cause, is determined by the state fire marshal to be a fire hazard; ( )

l. A building or structure, because of inadequate maintenance; dilapidation; decay; damage; faulty construction or arrangement; inadequate light, air or sanitation facilities; or otherwise, is determined to be unsanitary, unfit for human occupancy or habitation, or in such a condition that is likely to cause accidents, sickness, or disease; ( )

m. Any building or structure, because of dilapidated condition; deterioration; damage; inadequate exits; lack of sufficient fire-resistive construction; faulty electric wiring, gas connections, or heating apparatus; or other cause, is determined by the state fire marshal to be a fire or life safety hazard; and ( )

n. There is, within the building, the presence of vapors, fumes, smoke, dusts, chemicals, or materials in any form (natural or man made) in quantities that have been established by national health organizations to be a threat to the health or safety of the building occupants. This does not include materials stored, used, and processed in accordance with nationally recognized safety standards for the materials in question. ( )

051. -- 999. (RESERVED)

SUBCHAPTER A – GENERAL PROVISIONS
(Rules 000 - 050)

000. LEGAL AUTHORITY.
The rules are promulgated pursuant to Section 67-2601A, Idaho Code. ( )

001. SCOPE.
The rules are applicable to the logging industry in the state of Idaho. ( )

002. -- 006. (RESERVED)

007. DEFINITIONS A THROUGH C.
Terms used in these standards shall be interpreted in the most commonly accepted sense, excepting only those specifically defined. ( )

01. A-Frame. A structure made of the independent columns (of wood or steel) fastened together at the top and separated a reasonable width at the bottom to stabilize the unit from tipping sideways. ( )

02. Arch. A piece of equipment attached to the rear of a vehicle, used for raising one end of logs to facilitate skidding. ( )

03. Back Cut. The final falling cut. ( )

04. Barber Chair. Slab portion of tree remaining on the stump above the back cut due to improper falling. ( )

05. Bell. The component that slides on the cable and connects to the knob or button. When a worker chokes a log or stump, the bell secures the knob or button. ( )

06. Bight. The loop of a line, the ends being "gast" elsewhere, or the angle formed by a line running through a block. ( )

07. Binder. Chain, cable, or steel strap used for binding loads of logs. ( )

08. Brow Log. A log placed parallel to any roadway at a landing or dump to protect vehicles while loading or unloading. ( )

09. Bunk. The cross support for logs on a logging car or truck. ( )

10. Cable-Assisted Logging Systems. Logging systems, including, but not limited to, winch-assisted, cable-assisted, tethered, and traction-assisted systems that enable ground-based timber harvesting machines, including, but not limited to, feller bunchers, harvesters, loaders and shovels, to be operated on slopes. ( )

11. Carriage Logging. A type of high lead logging using gravity, haul back, or remote control carriages to yard logs. (Bullet carriage is one type). ( )

12. Chaser. The member of the yarding crew who unhooks the logs at the landing or fights hang-ups on skid road. ( )

13. Chock (Bunk Block-Cheese Block). A wedge that prevents logs from rolling off the bunks. ( )

14. Choker. A wire rope with special attachments put around the log near the end for hauling or lifting. ( )

15. Cold Shut. A link for joining two (2) chains, the link being closed cold with a hammer, not a weld. ( )

16. Competent Person. An individual who is capable of identifying existing and predictable hazards in the work site surroundings or working conditions that are unsanitary, hazardous or dangerous to employees, and

who has authorization to take prompt corrective measures to eliminate such. ( )

17. **Cutter**. A term used to designate faller or bucker. ( )

008. DEFINITIONS D THROUGH I.
Terms used in these standards shall be interpreted in the most commonly accepted sense, excepting only those specifically defined. ( )

01. **Equipment**. The term, as used, means and include all machines, machinery, tools, devices, safeguard, and protective facilities used in connection with logging operations, regardless of ownership. ( )

02. **Grapple**. A device attached to a hoisting line for mechanically handling logs. ( )

03. **Guarded**. Guarded means covered, shielded, or railed so as to remove the possibility of dangerous contact or approach by employees or objects. It further means construction of guards to ensure protection from flying objects where applicable. ( )

04. **Guy Lines**. The lines used to stay or support spar trees, booms, etc. ( )

05. **Haul Back**. A small wire line traveling between the power skidder and a pulley set near the logs. Used to return the main cable with tongs, chokers, or hooks to the next log. ( )

06. **Hazard**. Hazard, as used in these standards, means any condition or circumstance that may cause accident or injury to an employee. ( )

07. **Hook Tender, Hooker**. The worker who supervises the method of moving the logs from the woods to the place of loading. ( )

08. **It is Recommended, or Should**. When these terms are used they indicate provisions that are not mandatory. ( )

009. DEFINITIONS J THROUGH R.
Terms used in these standards shall be interpreted in the most commonly accepted sense, excepting only those specifically defined. ( )

01. **Jammer**. A machine used for handling logs. ( )

02. **Knob**. A metal ferrule arranged to be attached to the end of a line, used in place of a spliced eye. ( )

03. **Landing**. Any place where logs are placed, after being yarded, awaiting loading or unloading. ( )

04. **Leaners**. A live or dead leaning tree. ( )

05. **Loading Boom**. Any structure projecting from a pivot point to guide a log when lifted. ( )

06. **Log or Logs**. When the word log or logs is used, it includes poles, piling, pulpwood, skids, etc. ( )

07. **Operation (Show Woods Layout)**. Any place where logging is being done. ( )

08. **Mainline**. A cable which pulls logs or trees to loading. ( )

09. **Pike, Pole**. A long pole whose end is shod with a sharp pointed steel spike, point, or hook. ( )

10. Portable Spar or Tower. An engineered structure designed to be used in a manner similar to which a wooden spar tree would be used. ( )

11. Qualified Person. An individual who, by possession of a recognized degree, certificate or professional standing, or who by extensive knowledge, training and experience, has successfully demonstrated the ability to solve or resolve problems relating to the subject matter, the work, or the project. ( )

12. Reach. An adjustable beam between a trailer and a motorized logging vehicle. ( )

13. Running Line. Any line that moves. ( )

010. DEFINITIONS S THROUGH Z.

Terms used in these standards shall be interpreted in the most commonly accepted sense, excepting only those specifically defined. ( )

01. Safety Factor. This term as used is the ratio of the ultimate breaking strength of a member or piece of material to the actual working stress or to the maximum permissible (safe load) stress. For example: When a safety factor of six (6) is required, the structure, lines, hoists, or other equipment referred to shall be such as to provide a strength sufficient to support a load equal to six (6) times the total weight or stress to be imposed on it. ( )

02. Shall, Will. Is compulsory or mandatory. ( )

03. Skids. Any group of timbers spaced a short distance apart on which the logs are placed. ( )

04. Skidding. Movement of logs on the ground. ( )

05. Skyline. The supporting line on various types of logging systems on which carriage, block, or bullet travels. ( )

06. Snags. Any dead standing trees. ( )

07. Strap. Any short piece of line with an eye or "D" in each end. ( )

08. Strip. A definite location of timber allocated to a cutting crew. ( )

09. Substantial. Means constructed of such strength, of such material, and of such workmanship, that the object referred to will withstand normal wear, shock and usage. ( )

10. Tongs. A hooking device used to lift or skid logs. ( )

11. Undercut. A notch cut in the tree to guide and control the tree in falling. ( )

12. Yarding. Movement of logs or trees from the place they are felled (bucked) to a central loading or shipping point. ( )

011. INTERPRETATION AND APPLICATION OF THESE RULES.

01. Scope. These rules are part of the state of Idaho industrial accident prevention program and have the full force and effect of law. ( )

02. Jurisdiction. In accordance with the laws of the state of Idaho, every employer and every employee working in the state of Idaho shall comply with the rules contained herein. ( )

03. Enforcement. The enforcement of all rules of this chapter and the right of inspection and examination, at any time, shall rest with the Division. ( )

04. Issues Not Covered. Where specific standards in these rules fail to provide a rule or standard

applicable to the operation in question, and other state of Idaho codes or standards are applicable, those codes or standards shall apply. ( )

05. Interpretations. Should any controversy develop as to the intent or application of any standard or rule as set forth in these rules, or the interpretation of any standard or rule set forth in these rules, such controversy shall be called to the direct attention of the Division, which shall render a decision as the applicability of such rule or standard. Any appeal from this decision shall be directed to the Administrator. ( )

06. Additional Standards. It is recognized that a definite, positive safety standard cannot anticipate all contingencies. The Division, after due notice and opportunity to be heard, may require additional standards and practices to insure adequate safety at any place of any employment, and, on its own motion or upon application of any employer, employee, group, or organization, may modify any provision of this rule. ( )

07. Exceptions. In exceptional cases where the rigid application or compliance with a requirement can only be accomplished to the detriment and serious disadvantage of an operation, method, or process, exception to the requirement will be considered upon written application to the Division. After thorough investigation, the Division may grant an exception if human life and physical well being will not be endangered by such exception. ( )

08. Existing Buildings, Structures, and Equipment. Nothing contained in this rule for logging safety shall prevent the use of existing buildings, structures, and equipment during their lifetime when maintained in good safe condition, and properly safeguarded, or require conformance with the applicable safety standards required by Idaho Safety Codes effective prior to the effective date of this rule, provided that replacements and alterations shall conform with all provisions of these rules. ( )

012. EMPLOYER'S RESPONSIBILITY.

01. General Requirements. ( )

a. Every employer subject to these rules shall maintain places of employment that are safe according to the standards as set forth herein. ( )

b. Every employer shall adopt and use practices, means, methods, operations and processes that are adequate to render such employment and place of employment safe. ( )

i. Employers shall place highly visible “LOGGING AHEAD” or similar-type warning signs at the entrances of active logging jobs. Employers shall also place “TRUCKS AHEAD,” “TRUCKS ENTERING,” “TREE FALLING,” and “CABLES OVERHEAD,” whenever applicable ( )

ii. Every employer shall furnish to its crew a Company Emergency Rescue Plan. ( )

c. Every employer should insure that Safety Data Sheets (SDS) are reasonably accessible for every hazardous material. ( )

d. Every employer shall post and maintain in a conspicuous place or places in and about his place or places of business a written notice stating the fact that he has complied with the worker’s compensation law as to securing the payment of compensation to his employees and their dependents in accordance with the provisions of Idaho law. Such notice shall contain the name and address of the surety, as applicable, with which the employer has secured payment of compensation. Such notice shall also be readily available on the site where logging operations are occurring, and available for inspection by Division officials upon request. ( )

e. Every employer shall do all other things as required by these rules to protect the life and safety of employees. ( )

f. No employer shall require any employee to go or be in any place of employment that does not meet the minimum safety requirement of these rules, except for the purpose of meeting such requirements. ( )

g. No employer shall fail or neglect: ( )

i. To make available and use safety devices and safeguards as are indicated. ( )

ii. To adopt and use methods and processes adequate to render the employment and place of employment safe. ( )

iii. To do all other things as required by these rules to protect the life and safety of employees. ( )

h. No employer, owner or lessee of any real property shall construct or cause to be constructed any place of employment that does not meet the minimum safety requirements of these rules. ( )

i. No person, employer, employee, other than an authorized person, shall do any of the following: ( )

i. Remove, displace, damage, destroy or carry off any safeguard, first aid material, notice or warning, furnished for use in any employment or place of employment, or interfere in any way with the use thereof by any other person. ( )

ii. Interfere with the use of any method or process adopted for the protection of any employee, including himself, in such employment or place of employment. ( )

iii. No person shall fail or neglect to do all other things as required by these rules to protect the life and safety of employees. ( )

iv. The use of intoxicants or drugs while on duty is prohibited. Persons reporting for duty while under the influence of or impaired by liquor or other legal or illegal drugs or substances shall not work until completely recovered. ( )

j. A procedure for checking the welfare of all workers during working hours shall be instituted and all workmen so advised. The employer shall assume responsibility of work assignments so that no worker shall be required to work in a position or location so isolated or hazardous that he is not within visual or audible signal contact with another person who can render assistance in case of emergency. In any operation where cutting, yarding, loading, or a combination of these activities are carried on there shall be a minimum crew of two (2) persons who shall work as a team, and shall be in visual or audible signal contact with one another. This does not apply to operators of motorized equipment, watchmen, or certain other jobs which, by their nature are singular workmen assignments. There shall be some method of checking-in crew members at the end of the shift. Each immediate supervisor shall be responsible for his crew being accounted for. This standard also includes operators of movable equipment. ( )

k. Every employer shall keep a record of all cases of injuries his employees receive at their work. This record shall be kept in such manner as to enable representatives of the Division to determine by examining the record, the injury rate of the employee force for the period covered by the report. ( )

l. Every employer shall investigate every accident resulting in a disabling injury that his employees suffer in connection with their employment. Employers shall promptly take any required action to correct the situation. Employees shall assist in the investigation by giving any information and facts they have concerning the accident. ( )

02. Management Responsibility. ( )

a. Management shall take an active and interested part in the development and guidance of the operation’s safety program, including fire safety. ( )

b. Management shall apply a basic workable safety plan on the same priority as it does to any other work facet of the operation where elimination of all injuries is to be achieved in all phases of the operation. It is the duty of management to assume full and definite responsibility. To attain these safety objectives, management shall

have the full cooperation of employers and the Division. ( )

c. Every employer shall furnish employment which shall be safe for the employees therein and shall furnish such devices and safeguards and shall adopt and use such practices, means, methods, operation and processes as are adequate to render such employment and places of employment safe to protect the life and safety of employees. The employer shall make available necessary personal protective safety equipment. ( )

d. Regular safety inspection by a qualified person of all rigging, logging, machinery, rolling stock, bridges, and other equipment shall be made as often as the character of the equipment requires. Defective equipment or unsafe conditions found shall be replaced, repaired or remedied promptly. ( )

e. All places of employment shall be inspected by a qualified person or persons as often as the type of operation or the character of the equipment requires. Defective equipment or unsafe conditions found by these inspections shall be replaced or repaired or remedied promptly. ( )

013. EMPLOYEE'S RESPONSIBILITY.

01. General Requirements. ( )

a. Employees shall not indulge in activities that create or constitutes a hazard while on the employer's property or at any time when being transported from or to work in facilities furnished by the employer. ( )

b. Employees who are assigned to, or engaged in the operation of any machinery or equipment, shall ensure that all guards, hoods, safety devices, etc., that are provided by the employer are in proper place and properly adjusted. ( )

02. Employee Accidents. Each employee shall make it his individual responsibility to keep himself, his coworkers, and his machine or equipment free from accidents to the best of his ability. ( )

03. Study Requirements. So that each worker may be better qualified to cooperate with his fellow workmen in preventing accidents, he shall study and observe these and any other safety standards governing his work. ( )

04. Employee Responsibilities. Additional responsibilities of an employee insofar as industrial safety is concerned shall be as follows: ( )

a. Report immediately, preferably in writing, to his foreman or safety coordinator for the logging operation, all known unsafe conditions and practices. ( )

b. Ascertain from the foreman where medical help may be obtained if it is needed. ( )

c. Prompt reporting of every accident regardless of severity to the foreman, first aid attendant, or person in charge. Such reports are required and are necessary in order that there may be a record of his injuries. ( )

d. The employee shall at all times apply the principles of accident prevention in his daily work and shall use proper safety devices and protective equipment. No employee shall remove, displace, damage, destroy, or carry off any safety device or safeguard furnished and provided for use in any employment, or interfere in any way with the use thereof by any other person, or interfere with the use of any method or process adopted for the protection of any employee in such employment, or fail or neglect to do every other thing reasonably necessary to protect the life and safety of himself and fellow employees, and by observing safe practice rules shall set a good example for his fellow workmen. ( )

e. The employee shall not report to the job impaired by intoxicants or legal or illegal drugs and shall not use intoxicants or such drugs while on the job. The employer shall prohibit any employee from working on or being in the vicinity of any job while under the influence of or impaired by intoxicants or drugs. Employers shall be responsible for the actions of any employee known to be in an intoxicated or impaired condition while on the job.

( )

f. The employee shall wear, use and properly care for personal protective safety equipment issued to him. ( )

g. Workers exposed to head hazards shall wear approved head protection. ( )

h. Proper eye protection shall be worn while performing work where a known eye hazard exists. ( )

i. The employee should consider the benefits of accident prevention to himself and to his job. ( )

j. The employee should make an effort to understand his job. ( )

k. The employee should anticipate every way in which a person might be injured on the job, and conduct the work to avoid accidents. ( )

l. The employee should be on the alert constantly for any unsafe condition or practice. ( )

m. The employee shall learn first aid. ( )

n. The employee should keep physically fit, and obtain sufficient rest. ( )

o. The employee should be certain that all instructions received are understood completely before starting the work. ( )

p. The employee should actively participate in safety programs. ( )

q. The employee should study the safety educational material posted on the bulletin boards and distributed by the employer or safety committee. ( )

r. The employee should advise inexperienced fellow-employees of safe ways to perform their work and warn them of dangers to be guarded against. ( )

s. It is the employer's responsibility to ensure compliance with the foregoing provisions. ( )

014. -- 050. (RESERVED)

SUBCHAPTER B – HEALTH, SAFETY, AND SANITATION
(Rules 051 through 100)

051. FIRST AID.

01. Transportation. ( )

a. Suitable means of transportation shall be established and maintained at the site of all operations to be used in the event any employee is seriously injured. ( )

b. Each crew bus, or similar vehicle, shall be equipped with at least one (1) first aid kit with the required contents as indicated in Subsection 051.06 of this rule. ( )

02. Communication. ( )

a. Every employer shall arrange suitable telephone or radio communication at the nearest reasonable point, and shall establish an emergency action plan to be taken in the event of serious injury to any employee. ( )

b. Instructions covering the emergency action plan shall be made available to all work crews. ( )

c. When practicable, a poster shall be displayed on, or near the cover of each first aid cabinet or phone. The poster shall display the phone numbers of applicable emergency services. The use of the Idaho State EMS Communication Center is recommended. The number is 1-800-632-8000 or 208-846-7610. ( )

d. Every employer shall obtain their specific job location (longitude and latitude preferred) and furnish such to crew for emergency evacuation. ( )

03. Attendance for Seriously Injured. ( )

a. Seriously injured employees shall, at all times, be attended by the most qualified available person to care for the injured employees. ( )

b. Seriously injured employees shall be carefully handled and removed to a hospital, or given medical attention as soon as possible. ( )

c. Caution shall be used in removing a helpless or unconscious person from the scene of an accident to prevent further injury. ( )

04. First Aid Training. Any person performing work associated with a logging operation shall be required to complete an approved course in first-aid and have a current card. ( )

05. Stretcher or Spine Board. A spine board (designed for or adaptable to the work location and terrain) and two blankets maintained in sanitary and serviceable condition shall be available where such conditions require the use of such to provide for the proper transportation and first aid to an injured workman. ( )

06. First Aid Kits. ( )

a. The employer shall provide first aid kits that are readily available and supplied as required at each work site where trees are being felled, at each active landing, and in each employee transport vehicle. ( )

b. The following list sets forth the minimally acceptable number and type of first-aid supplies for required first-aid kits. The contents of the first-aid kits shall be adequate for small work sites, consisting of approximately two (2) to three (3) employees. When larger operations or multiple operations are being conducted at the same location, additional first-aid kits shall be provided at the work site or additional quantities of supplies shall be included in the first-aid kits:

TABLE 051.06 – REQUIRED FIRST-AID KIT CONTENTS	
1.	Gauze pads (at least 4 x 4 inches)
2.	Two (2) large gauze pads (at least 8 x 10 inches)
3.	Box adhesive bandages (band-aids)
4.	One (1) package gauze roller bandage (at least two (2) inches wide)
5.	Two (2) triangular bandages
6.	Wound cleaning agent such as sealed moistened towelettes
7.	Scissors
8.	At least one (1) blanket
9.	Tweezers

TABLE 051.06 – REQUIRED FIRST-AID KIT CONTENTS	
10.	Adhesive tape
11.	Latex gloves
12.	Resuscitation equipment such as resuscitation bag, airway, or pocket mask
13.	Two (2) elastic wraps
14.	Splint
15.	Directions for requesting emergency assistance

( )

c. Special kits, or the equivalent, shall be provided and approved for special hazards peculiar to any given work location. ( )

d. First aid kits shall be in sanitary containers. Such containers shall be designed and constructed so as to be impervious to conditions of weather, dust, dirt, or other foreign matter. ( )

052. SAFETY EQUIPMENT AND PERSONAL PROTECTIVE EQUIPMENT.

01. General Requirements. ( )

a. Special protective equipment or apparel required for safe employment, other than clothing or equipment customarily supplied by employees, shall be furnished by the employer where necessary for the safety of employees. ( )

b. Employees are required to utilize all prescribed safety equipment and special protective equipment or apparel, and they shall exercise due care in maintaining it in safe, efficient and sanitary conditions. ( )

c. Employers are required to provide, at no cost to employees, appropriate eye, face, head, hand, and leg protection. ( )

d. Defective safety equipment shall not be used. Where the need for their use is indicated, protective covering, ointments, gloves or other effective protection shall be provided for and used by persons exposed to materials that are irritating to the skin. ( )

02. Inspection, Maintenance and Sanitizing. ( )

a. Each employer shall maintain a regular system of inspection and maintenance of personal protective equipment furnished to workers. ( )

b. Air line equipment shall have a necessary regulator and shall be inspected before each use. ( )

c. Workers shall check their equipment at the beginning of each shift. ( )

03. Eye Protection. ( )

a. Where workers are subject to eye hazards (flying particles, dusts, hazardous liquids, gases, mists or vapors, or injurious light rays) they shall be furnished with and shall wear eye protection suitable for the hazards involved. Such eye protection shall conform to the American National Standard Institute standards for Head, Eyes and Respiratory protection. ( )

b. Face shields may be used in lieu of other forms of eye protection where the nature of the operation is such that they will furnish equivalent protection. ( )

c. Clean water in ample quantities shall be immediately available where materials are handled that are caustic or corrosive to the eyes. ( )

04. Foot and Leg Protection. ( )

a. Employees shall wear footwear suitable for the work conditions. ( )

b. Employees shall wear sharp caulk-soled boots or other footwear which will afford maximum protection from slipping. ( )

c. Special types or designs of shoes, or foot guards, shall be required to be worn where conditions exist that make their use necessary for the safety of the workers. ( )

d. Leggings or high boots of leather, rubber or other suitable material shall be worn by climbers, persons exposed to hot substances, or caustic solutions, etc., or where poisonous snakes may be encountered. ( )

e. Each employee who operates a chain saw shall wear leg protection, which meets the requirements of ASTM F 1897 and covers the full length of the thigh to the top of the boot on each leg, except when working as a climber. ( )

05. Hand Protection. ( )

a. Hand protection suitable for the required usage shall be worn wherever the nature of the work requires extra protection for the hands. ( )

b. Gloves shall not be worn where their use would create a hazard. ( )

06. Head Protection. ( )

a. Persons required to work where falling or flying objects, overhead structures, exposed electrical conductors, equipment or material create a hazard shall wear approved safety hard hats or caps at all times while exposed to such hazards. ( )

b. Employees working in locations which present a catching or fire hazard to hair shall wear caps or other head protection that completely covers the hair. ( )

07. Life Jackets, Vests and Life Rings.
Where personal buoyancy equipment is provided, it shall be of a design and shall be worn in a manner that will maintain the wearer's face above water. It shall be capable of floating a sixteen (16) pound weight for three (3) hours in fresh water. Such equipment shall not be dependent upon manual or mechanical manipulation or chemical action to secure the buoyant effect. ( )

a. Employees shall be provided with, and shall wear, approved buoyant protective equipment at all times while working on or over water, as follows: ( )

i. On floating pontoons, rafts and floating stages. ( )

ii. On open decks of floating plants (such as dredges, pile-drivers, cranes, pond saws, and similar types of equipment) which are not equipped with bulwarks, guardrails or life lines. ( )

iii. During the construction, alteration or repair of structures extending over or adjacent to water, except when guardrails, safety nets, or safety belts and life lines are provided and used. ( )

iv. Working alone at night where there are potential drowning hazards regardless of other safeguards provided. ( )

v. On floating logs, boom sticks or unguarded walkways. ( )

b. Life rings with sufficient line attached to meet conditions shall be located at convenient points along exposed sides of work areas adjacent to water. Such rings, if used at night where a person might be beyond illuminated areas, shall be provided with a means of rendering them visible.
NOTE: Consult U.S. Coast Guard requirements for operations in navigable waters. ( )

08. Life Lines -- Safety Belts. ( )

a. Each life line and safety belt shall be of sufficient strength to support, without breaking, a weight of two thousand five hundred (2,500) pounds. ( )

b. All life lines and safety belts shall be periodically inspected by the supervisor in charge. Employees shall inspect their belts and lines daily. Any defective belts or life lines shall be discarded or repaired before use. ( )

c. Life lines shall be safely secured to strong stable supports and maintained with minimum slack. ( )

09. Work Clothing. ( )

a. Clothing shall be worn which is appropriate to work performed and conditions encountered. ( )

b. Loose sleeves, cuffs or other loose or ragged clothing shall not be worn near moving machinery. ( )

c. Clothing saturated or impregnated with flammable liquids, corrosive substances, irritants or oxidizing agents shall be removed immediately and not worn again until properly cleaned. ( )

d. When it is necessary for workers to wear aprons or similar clothing near moving machines or hazardous materials, such clothing shall be so arranged that it can be instantly removed. ( )

e. Clothing with exposed metal buttons, metal visors or other conductive materials shall not be worn around exposed electrical conductors. ( )

10. Respiratory Equipment. ( )

a. When filter or cartridge-type respirators are required to be used regularly, each employee shall have one such respirator for his own exclusive use. ( )

b. Employers and employees shall familiarize themselves with the use, sanitary care and limitations of such respiratory equipment as they may have occasion to use. ( )

c. Whenever practical, harmful dusts, fumes, mists, vapors and gases shall be suppressed by water, oil or other means which will minimize harmful exposure and permit employees to work without the use of respiratory equipment. ( )

d. Whenever compressed air from an oil-lubricated compressor is used to supply respiratory equipment, a filter shall be inserted in the supply line to remove any oil, sediment or condensation that it may contain. Such filter shall be maintained in efficient working condition. ( )

e. When self-contained respiratory equipment is used in hazardous locations, a standby unit shall be maintained for rescue purposes. ( )

11. Hearing Protection. Where workers are subject to hazardous noise levels, they shall be furnished

with and shall wear hearing protection suitable for the level of hazard involved. ( )

12. Additional Information and Requirements. Additional information and requirements for the use of safety equipment and personal protective equipment may be found in the Safety and Health Standards established in IDAPA 07.09.01, "Safety and Health Rules for Places of Public Employment." ( )

053. FIRE PREVENTION, PROTECTION AND SUPPRESSION.

01. General Requirements. ( )

a. Additional Standards pertinent to the storage, distribution, and use of liquefied petroleum gases and other flammables or combustibles may be obtained by reference to regulations of the Idaho State Fire Marshal and the National Fire Protective Association pamphlets. ( )

b. Fire fighting equipment, suitable for the hazards involved, shall be provided for the protection of workmen. Such equipment shall be readily accessible, and shall be plainly labeled as to its character and method of operation. Locations of such equipment shall be conspicuously posted. ( )

c. All equipment and apparatus for fire protection and fire fighting shall be regularly inspected and be maintained in good and serviceable condition at all times. A record of the date of the latest inspection shall be kept with each portable fire extinguisher. This includes all automatic sprinkler systems and hose lines. ( )

d. Fire extinguishers, whether portable or automatic, shall comply with appropriate current standards as published by the National Fire Protection Association. Portable fire extinguishers shall also be subject to an annual maintenance inspection by the Division. They must also be visually inspected by the employer each month, and such inspections documented. ( )

e. Electrical lights, apparatus, and wiring used in locations where flammable or explosive gases, vapors, mists, or dusts are present shall be of the type accepted by the adopted Electrical Code for the State of Idaho. ( )

f. Smoking while refueling equipment is prohibited. ( )

g. All fuel storage tanks, service tanks, etc., shall be bonded for ground for fueling purposes. ( )

h. When lights are used in enclosed rooms, vaults, manholes, tanks or other containers which may contain flammable or explosive vapors, mists, gases, or dusts, such lights shall be of the approved vapor proof types. ( )

i. No torch, flame, arc, spark, or other source of ignition shall be applied to any tank or container that has contained or does contain flammable or explosive vapors or materials until such container has been made to be inert or otherwise purged of flammable or explosive vapors or materials, except that "hot tapping" on tanks may be done provided that: ( )

i. There shall be at least four (4) feet of liquid above the point of the "hot tap"; and ( )

ii. The work shall be carried out under the direction of a supervisor experienced in this type of work.

NOTE: A test for flammability or explosiveness of the interior of such vessels shall be made using a device which will determine the concentration of flammable vapors for this purpose. Unless the percentage of flammable vapors is found to be less than twenty percent (20%) of its lower explosive limit, no source of ignition shall be permitted. ( )

j. Frequent testing for determining the concentration of flammable and explosive vapors shall be made, and if the concentration is found to exceed twenty percent (20%) of its lower explosive limit, sources of ignition shall be extinguished or removed immediately. Fire extinguishing equipment adequate to cope with possible hazards shall be maintained close at hand. ( )

k. Smoking, the use of open flames, tools which are not approved for such areas, and other sources of ignition are prohibited in locations where flammable or explosive gases, vapors, mists, or dusts are present. Warning signs shall be conspicuously posted in such areas. ( )

l. Where salamanders and other fuel-burning heating devices are used, they shall be provided with adequate means for preventing the emission of sparks or other sources of ignition. Such devices shall be insulated or placed a sufficient distance from combustible structures and materials to prevent causing fires. Adequate ventilation shall be provided. ( )

m. When welding or cutting is done special precautionary measures shall be exercised before, during and after the job is finished to eliminate any possibility of immediate or delayed fires. ( )

02. Flammable Liquids. ( )

a. For the purpose of this section, "Flammable Liquids" shall mean any liquid having a flash point below one hundred forty (140) degrees Fahrenheit and having a vapor pressure not exceeding forty (40) pounds per square inch (absolute) at one hundred (100) degrees Fahrenheit. ( )

b. All flammable liquids shall be stored in approved containers suitable for their particular contents, and such approved containers shall be stored in areas removed from any direct source of ignition. ( )

c. Flammable liquids shall be kept in approved covered containers when not in actual use. ( )

d. The name of the flammable liquid contained therein shall be placed on all stock containers, and whenever such liquids are taken from the stock containers and put into other approved containers for use, it shall be the responsibility of the employer to ensure that these containers (except small containers of flammable liquids which are scheduled for immediate use and disposal) also bear the name of the flammable liquid contained therein. ( )

e. Flammable liquids shall not be used indoors to clean or wash floors, walls, any part of a building structure, furniture, equipment, machines or machine parts, unless sufficient ventilation is provided to bring and maintain the concentration of explosive vapors in the atmosphere below twenty percent (20%) of its lower explosive limit.

NOTE: The use of flammable liquids may create toxic contaminants in the atmosphere above permissible threshold limit values. ( )

03. Transferring Flammable Liquids and Powdered Materials. In transferring flammable liquids or finely divided flammable or explosive materials from one metal container to another, the containers shall be in firm contact with each other or be continuously bonded throughout the transfer so as to prevent the accumulation of static charges. Where portable tanks, mixers, or processing vessels are used for flammable liquids or flammable or explosive compounds, they shall be bonded and grounded while being filled or emptied. ( )

04. Transportation of Flammable Liquids. ( )

a. When transporting gasoline or other flammable liquids, approved containers shall be used. ( )

b. If tank truck service is not available or used, gasoline and other flammable liquids shall be transported in approved containers. Bungs shall be tight and containers shall be secured to prevent movement. ( )

c. It may be permissible to transport gasoline or other flammable liquids on passenger vehicles if in approved, closed safety containers of not more than six and one-half (6 1/2) gallon capacity, provided such containers are carried in a suitable and safe location outside the passenger compartment. ( )

054. -- 100. (RESERVED)

SUBCHAPTER C – GARAGES, MACHINE SHOPS, AND RELATED WORK AREAS
(Rules 101 - 150)

101. GARAGES AND MACHINE SHOPS AND RELATED AREAS.

01. General Requirements. ( )

a. Machine shops and other structures where workers are employed shall be constructed, ventilated, lighted and maintained in a safe working condition. ( )

b. Engines, pulleys, belts, gears, sprockets, collars and other moving parts of machinery shall be properly guarded. ( )

c. Grinding wheels shall have proper and adequate eye guards or hoods. Face shields shall be worn by employees while grinding. ( )

d. Machines shall be in good repair and good housekeeping shall be maintained. ( )

e. Proper goggles or hoods shall be made available and used in grinding and cutting, acetylene welding, electric arc and other types of welding. ( )

f. Tools shall be kept in good condition and care shall be taken in the handling and storing of all tools and materials so as to minimize chances for injury. ( )

g. An approved screen shall be provided, and used, to protect other workers from welding flashes. ( )

102. -- 150. (RESERVED)

SUBCHAPTER D – SIGNALS AND SIGNAL SYSTEMS
(Rules 151 - 200)

151. GENERAL REQUIREMENTS.

01. Rigging.

a. Rigging shall be moved by established signals and procedures only. ( )

b. Signals shall be thoroughly understood by the crew. ( )

02. Daily Test Required. Each electric or radio signal system shall be tested daily before operations begin. ( )

03. Personnel in Clear Before Moving Logs or Turns. ( )

a. Operators of yarding equipment shall not move logs or turns until all personnel are in the clear and a signal has been given. ( )

b. Operators of yarding equipment shall be alert to signals at all times. ( )

152. SIGNALING.

01. One Worker to Give Signals. ( )

a. The Worker sending drag shall be the only one to give signals. ( )

b. Any person is authorized to give a stop signal when a worker is in danger or other emergency conditions are apparent. ( )

02. Signal Must Be Clear and Distinct. ( )

a. Machine operators shall not move any line unless the signal received is clear and distinct. ( )

b. If in doubt the operator shall repeat the signal as understood and wait for confirmation. ( )

03. Hand Signal Use Restricted. ( )

a. Hand signals are permitted only when in plain sight of the operator. ( )

b. Hand signals may be used at any time as an emergency stop signal. ( )

04. Persons in Clear Before Signal Given. All persons shall be in the clear before a signal is given to move logs or turns. ( )

05. Throwing Material Prohibited. Throwing of any type of material as a signal is prohibited. ( )

06. Audible Signaling to Be Installed and Used. A whistle, horn or other audible signaling device, clearly audible to all persons in the affected area, shall be installed and used on all machines operating as yarders. ( )

07. Audible Signaling Device at the Machine to Be Activated. When radio or other means of signal transmission is used, an audible signal must be activated at the machine. ( )

153. ELECTRIC SIGNAL SYSTEMS.

01. Weatherproof Wire and Attachments to Be Used. Where an electrical signal system is used, all wire and attachments shall be of the weather proof type. ( )

02. Electric Signal Systems to Be Properly Installed and Adjusted. Electric signal systems shall be properly installed and adjusted as necessary. They shall be protected against accidental signaling, and shall be maintained in good operating condition at all times. ( )

03. All Connections to Be Weatherproof. All connections in insulated signal wire shall be weatherproof. ( )

154. RADIO SIGNALING SYSTEMS.

01. Use of Conventional Space Transmission of Radio Signals. When conventional space transmission of radio signals is used under and in accordance with an authorization granted by the Federal Communications Commissions to initiate any whistle, horn, bell or other audible signaling device, or such transmission of radio signals is used to activate or control any equipment, the following specific rules contained in this section will apply.

NOTE: This rule shall apply only to devices operating on radio frequencies authorized pursuant to the rules and regulations of the Federal Communications Commission. ( )

02. Description on Outside of Case. ( )

a. Each radio transmitter and receiver shall have its tone frequency(s) in hertz (CPS), the manufacturer's serial number, and the assigned radio frequency clearly and permanently indicated on the outside of the case. ( )

b. When the duration of a tone frequency performs a function, the pulse-tone duration shall also be permanently indicated on the outside of the case. ( )

c. On the FCC restricted frequencies one hundred fifty-four point fifty-seven (154.57) MHZ and one hundred fifty-four point sixty (154.60) MHZ, a maximum of two (2) watts of power will be allowed. ( )

03. Activating Pulse-Tone Limitations. The activating pulse-tone of any multi-tone transmitter shall be of not more than forty (40) milliseconds duration. ( )

04. Adjustment, Repair or Alteration. All adjustments, repairs or alterations of radio-signaling devices shall be done only by or under the immediate supervision and responsibility of a person holding a first or second class commercial radio operator's license, either radio-telephone or radio-telegraph, issued by the Federal Communications Commission. ( )

05. Testing of Tone-Signal Controlled Devices. ( )

a. Tone-signal controlled devices shall be tested each day before work begins. If any part of the equipment fails to function properly, the system shall not be used until the source of trouble is detected and corrected. ( )

b. Audible signals used for test purposes shall not include signals used for movement of lines or material.

NOTE: Equipment or machines controlled by radio-signaling devices shall be designed and built to "fail safe" or stop, in case of failure of the radio-signaling device. ( )

06. Interference, Overlap, Fade-Out or Blackout. When interference, overlap, fade-out or blackout of radio signals is encountered, the use of the tone-signal controlled device shall be immediately discontinued. The use of such tone-signal controlled device shall not be resumed until the source of trouble has been detected and corrected. ( )

07. Number of Transmitters Required. ( )

a. Two (2) radio transmitters shall be in the vicinity of the rigging crew at all times when transmitters are being used by persons who are around the live rigging. ( )

b. Only one (1) radio transmitter shall be required, if in possession of a signalman who has no other duties and remains in an area where he is not subjected to hazards created by moving logs or rigging. ( )

08. Voice Communication. ( )

a. Voice Communication shall be used for explanation purposes only. ( )

b. Actual activation of equipment shall be done by audible horn, bell or whistle and not by voice. ( )

c. The signal must be audible throughout the entire yarding and machine area. ( )

155. -- 200. (RESERVED)

SUBCHAPTER E – TRUCK ROAD STANDARDS
(Rules 201 - 250)

201. TRUCK ROAD STANDARDS.

01. Building Roads. ( )

a. When building roads, all construction shall be carried on in accordance with good logging engineering practices and shall be constructed and maintained in a manner to insure reasonably safe operation. ( )

b. The due consideration shall be given to the following factors: ( )

i. The type of material used for roadbed and surfacing. ( )

ii. The type of hauling equipment which will travel road. ( )

iii. The size of loads to be hauled. ( )

iv. The pitch and length of grades. ( )

v. The degree of curvature and visibility on turns. ( )

vi. The volume of traffic. ( )

c. Truck roads shall not be too steep for safe operation of logging, or work trucks which operate over them, and should not exceed twenty percent (20%) grade unless an auxiliary means of truck lowering is provided. ( )

d. Sufficient turnouts shall be provided and a safe side clearance maintained along all truck roads. ( )

e. Brush and other materials that obstruct the view at intersections or on sharp curves shall be eliminated and all possible precautions taken. ( )

f. Culverts and bridge structures shall be adequate to support the maximum imposed loads without exceeding the maximum safe working unit stresses. Such structures shall be maintained in good condition and shall be inspected annually by a qualified individual. ( )

g. Dangerous trees, snags and brush, which may create a hazard shall be cleared a safe distance on both sides of the right-of-way. ( )

02. Main Truck Roads. ( )

a. Main truck roads shall be of sufficient width and evenness to insure the safe operation of equipment. ( )

b. Truck roads with blind curves where visibility is less than three hundred (300) feet shall be of sufficient width for two (2) trucks to pass, controlled by some type of signal system, or speed shall be limited to fifteen (15) miles per hour. ( )

c. Conditions such as broken planking, deep holes, large rocks, logs, etc., which prevent the safe operation of equipment shall be immediately corrected. ( )

d. Wheel guard rails on bridges shall be not less than eight (8) inches above deck and shall be substantially fastened to withstand impact of shearing wheels. Such guard rails shall extend the full length of the bridge. ( )

03. Operation of Equipment. Excavators, tractors, bulldozers, and other equipment shall be operated in a safe and careful manner. All precautions shall be taken to insure the safety of all employees. ( )

202. -- 250. (RESERVED)

SUBCHAPTER F – TRANSPORTATION OF EMPLOYEES
(Rules 251 - 300)

251. TRANSPORTATION OF EMPLOYEES.

01. General Requirements. ( )

a. Anchored seats and seat belts shall be provided for each person riding in any vehicle. ( )

b. Vehicles used for the transportation of employees shall be constructed or accommodated for that purpose, and shall be equipped with adequate seats with back rests properly secured in place. Vehicles shall be protected on their sides and ends to prevent falling from the vehicle. ( )

c. Vehicles, as described above, shall be equipped with adequate steps, stirrups, or other similar devices, so placed and arranged that the employees can safely mount or dismount the vehicle. ( )

d. Vehicles designed to transport nine (9) or more passengers, shall be equipped with an emergency exit not less than six and one-half (6 1/2) feet in area, with the smaller dimension being not less than eighteen (18) inches. Such exit shall be placed at or near the back of the vehicle on the side opposite the regular entrance. The route to and egress from the exit must be unobstructed. ( )

e. Every emergency exit shall be conspicuously marked "Emergency Exit," and be so fastened that it can be readily opened by a passenger in the case of emergency. ( )

f. Emergency doors shall be not less than twenty-four (24) inches in width. ( )

g. Every vehicle used for the transportation of employees shall be equipped with an Underwriters Laboratories, Inc. approved fire extinguisher, or its equivalent, with at least a four (4) BC rating. ( )

h. All drivers of vehicles used for the transportation of employees shall have an appropriate operator's license for the state of Idaho. ( )

i. Drivers shall inspect vehicles before operating them. If a vehicle is found to be unsafe, it shall be reported to a proper authority and shall not be operated until it has been made safe. ( )

j. Brakes, steering mechanism and lights shall be tested immediately before starting any trip. ( )

k. No flammable materials, or toxic substances shall be transported in passenger compartments of vehicles while carrying personnel. ( )

l. Transporting more individuals than the seating capacity of the vehicle is permitted only under emergency conditions. Should it become necessary in an emergency, all employees not having seats must ride within the vehicle. ( )

m. Under no circumstances shall employees ride on fenders or running boards. ( )

n. An employee must never ride in, or on, any vehicle with his legs hanging over the end or sides. ( )

o. If tools are transported at the same time that employees are being transported, the tools shall be enclosed in boxes or racks and properly secured to the vehicle. ( )

p. No one shall board, or leave, moving equipment except in the case of an emergency (except trainmen or others whose duties require such). ( )

q. Equipment shall be operated in a safe manner and in compliance with traffic regulations. Safe

speeds shall be maintained at all times. ( )

r. No explosives shall be transported on, or in, vehicles used primarily for carrying personnel while such vehicles are being used for carrying personnel. ( )

s. The driver shall do everything reasonably possible to keep vehicles under control at all times, and shall not operate vehicles at excessive speeds. The driver shall take into consideration the condition of the roadway, weather factors, curves, grades and grade crossings, the mechanical condition of the vehicle and equipment and other pertinent items. The driver shall clear rocks from between dual tires before driving on multi-lane roads. A daily inspection shall be made of trucks and trailers with particular attention to steering apparatus, brakes, boosters, brake hoses and connections, reaches and couplings. Any defects found shall be corrected before the equipment is used. ( )

252. -- 300. (RESERVED)

SUBCHAPTER G – FALLING AND BUCKING
(Rules 301 - 350)

301. FALLING AND BUCKING.

01. General Requirements. ( )

a. There shall be an established method of checking-in workers from the woods. Each supervisor shall be responsible for their crew being accounted for at the end of each shift. ( )

b. Cutters not in sight of another employee shall have radio communications with crew members on that job site. ( )

c. Common sense and good judgment must govern the safety of cutters as effected by weather conditions. At no time shall they work if wind is strong enough to prevent the falling of trees in the desired direction, or when vision is impaired by weather conditions or darkness. ( )

d. All cutters shall have a current first aid certification. Employers shall provide an opportunity for cutters to take a standard first aid course. ( )

e. Tools of cutters such as axes, sledges, wedges, saws, etc., must be maintained in safe condition. Battered sledges, and wedges shall not be used. When power saws are used, wedges shall be made of soft material, such as wood or plastic. ( )

f. Cutters shall not be placed on hillsides immediately below each other or below other operations where there is possible danger. ( )

g. Trees shall not be felled if a falling tree endangers any worker, line, or any unit in operation. ( )

h. Before starting to fall or buck any tree or snag, the cutter must survey the area for possible hazards and proceed according to safe practices. Snags, which are unsafe to cut, shall be blown down with explosives, or felled by other methods. ( )

i. Dangerous or hazardous snags shall be felled prior to or in the course of cutting a strip. No danger tree shall be felled by one (1) cutter where and when the assistance of a fellow employee is necessary to minimize the danger or hazards involved. In the case that any danger tree or snag cannot be safely felled and must remain standing or unattended, such tree or snag shall be clearly identified and suitably marked, including all surrounding impact area, and the employee's supervisor shall be notified as soon as possible. ( )

j. In falling timber, adjacent brush and snow shall be cleared away from and around the tree to be felled to provide sufficient room to use saws and axes and provide an adequate escape path. ( )

k. Cutters shall not fall into another strip; leaners on the line shall be traded. Trees shall be felled into the open whenever conditions permit. ( )

l. Undercuts and side cuts shall be large enough to safely guide the trees and eliminate the possibility of splitting and barber chairing. Particular care shall be taken to hold enough wood to prevent the tree from prematurely slipping or twisting from the stump. Undercuts shall be cleaned out to the full depth of the saw cut. Especially large undercuts are necessary in heavy leaners. When required to safely fell a tree, mechanical or other means shall be employed to accomplish this objective. Pre-cutting of trees for the purpose of production logging is prohibited.

NOTE: Trees with no perceptible lean having an undercut to a depth of one quarter (1/4) of the diameter of the tree with an undercut height equal to one fifth (1/5) of the diameter of the tree will be assumed to be in reasonable compliance with this rule. ( )

m. Back-cuts shall be above the level of the upper horizontal cut of the undercut. ( )

n. While wedging, fallers shall watch for limbs or other material which might be jarred loose. Cutting of holding wood in lieu of using wedges is prohibited. ( )

o. When falling or bucking a tree is completed the power saw motor should be stopped. The power saw motor shall be stopped while the operator is traveling to the next tree. ( )

p. Cutters shall not work on the downhill side of the log being bucked unless absolutely unavoidable and only when the log is blocked or otherwise secured to prevent rolling when cut is completed. ( )

q. Cutters must give timely warning to all persons within range of any log which may have a tendency to roll or slide after being cut off. ( )

r. Logs shall be completely bucked-through whenever possible. If it becomes hazardous to complete a cut, then the log shall be marked and identified by a predetermined method. Rigging crews shall be instructed to recognize such marks and when possible cutters shall warn rigging crew of locations where such unfinished cuts remain. ( )

s. A competent person properly experienced in this type of work shall be placed in charge of falling and bucking operations. Inexperienced workers shall not be allowed to fall timber or buck logs unless under the direction of experienced workers. ( )

t. Power saws shall be kept in good repair at all times. All exhaust parts on power chain saws shall be constructed and maintained so the operator is exposed to a minimum amount of fumes and noise. ( )

u. Combustion engine driven power saws shall be equipped with an automatic throttle which will return the motor to idling speed upon release of the throttle. ( )

v. Power saw motors shall be stopped while being fueled. ( )

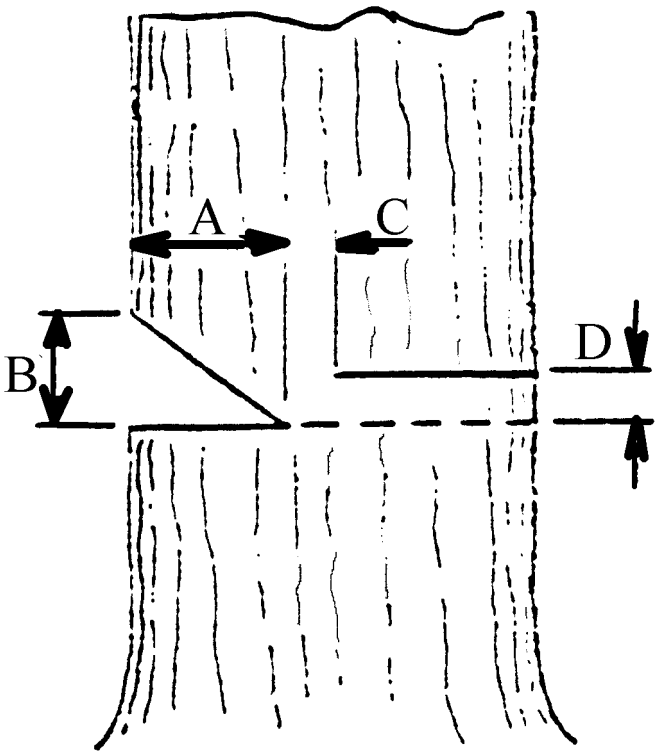
w. All personnel shall wear approved head protection, proper clothing and footwear. ( )

x. Each employee who operates a chain saw shall wear leg protection, which meets the requirements of ASTM F 1897 and covers the full length of the thigh to the top of the boot on each leg, except when working as a climber. ( )

302. ILLUSTRATION OF UNDERCUTS.

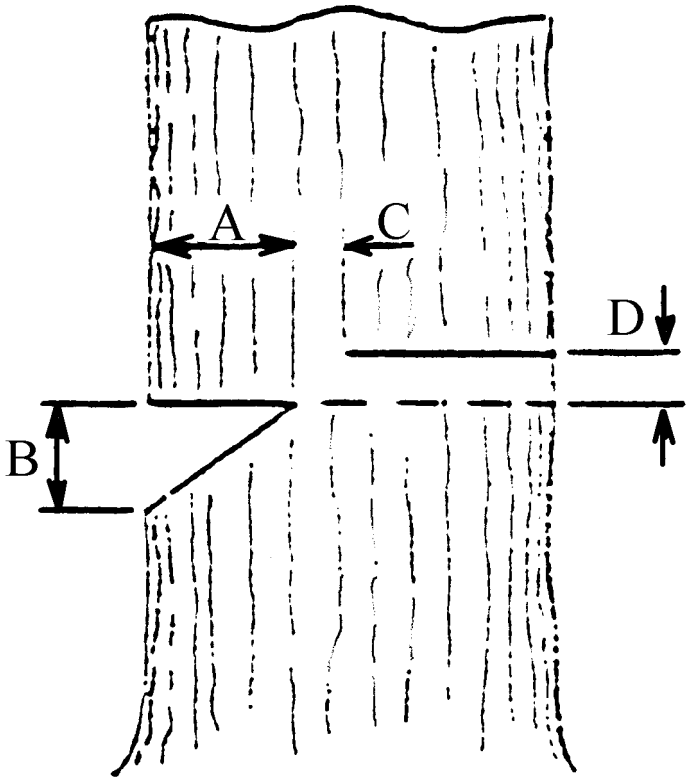
01. Illustration of Undercuts. ( )

FIGURE 302.01.a. – CONVENTIONAL UNDERCUT



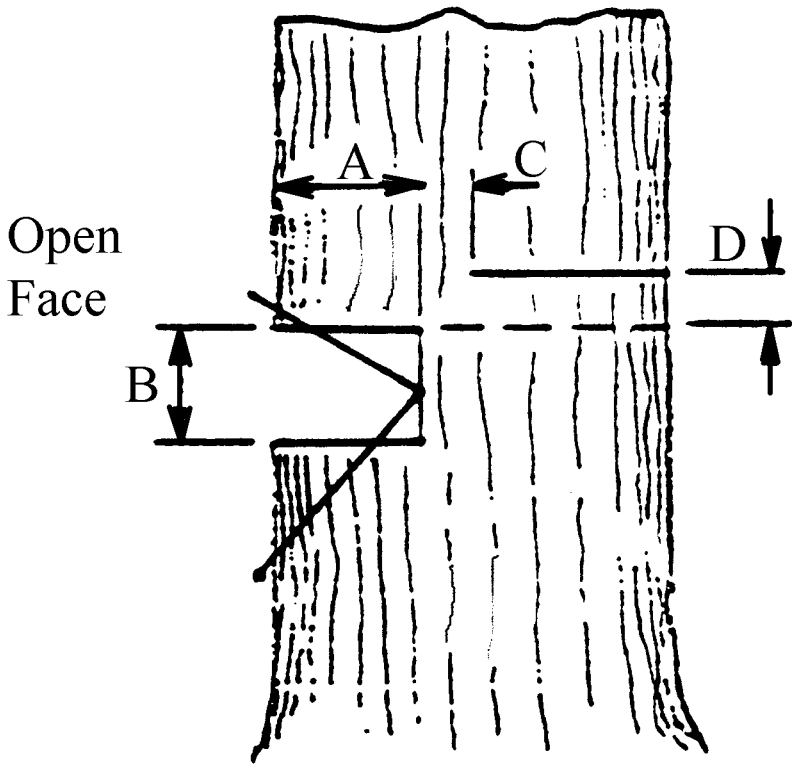
a. Conventional Undercut. May be made with parallel saw cut and a diagonal cut. Backcut (D) shall be above undercut. ( )

FIGURE 302.01.b. – HUMBOLT UNDERCUT



b. Humbolt Undercut. A cut in which both cuts made with the saw leaves a square end log (See Figure 302.01.b.). The cut is the same as a conventional cut (See Figure 302.01.a.) except that waste is on the stump. Backcut (D) shall be above undercut. ( )

FIGURE 302.01.c. – OPEN FACE UNDERCUT



c. Open Face Undercut. A cut in which two (2) angle cuts are made with the saw (See Figure 302.01.c.) -- It is used when it is necessary that the face does not close until the tree is near the ground. ( )

303. MECHANICAL DELIMBERS AND FELLER BUNCHERS.

01. General Requirements. ( )

a. Before start-up or moving equipment, check the surrounding area for fellow employees or equipment. ( )

b. If any protective device is missing, it is to be replaced as soon as possible. If it affects a safe operation, the machine is to be shut down. ( )

c. When a machine is working, extreme caution shall be used when approaching. The operator shall be notified by radio or visual contact. ( )

d. All raised equipment shall be lowered to the ground or to a safe position and the park brake set before leaving the machine. ( )

304. -- 350. (RESERVED)

SUBCHAPTER H – RIGGING, LINES, BLOCKS, AND SHACKLES (Rules 351 - 400)

351. RIGGING.

01. General. The determining factor in rigging-up shall be the amount of rated stump pull which a machine can deliver on each line. ( )

02. Equipment Classification. ( )

a. Equipment shall be classed according to the manufacturer's rating. ( )

b. Where lower gear ratios or other devices are installed to increase the power of equipment, the size of the rigging shall be increased proportionately so that it will safely withstand the increased strains to conform to Subsection 010.04 of these rules. ( )

03. Safe Loading. Rigging, and all parts thereof, shall be of a design and application to safely withstand all expected or potential loading to which it will be subjected. ( )

04. Allowable Loading or Stress. ( )

a. In no case shall the allowable loading or stress be imposed on one half (1/2) of the rated breaking strength of any parts of the rigging. ( )

b. This shall not be construed as applying to chokers. ( )

05. Chokers. Chokers shall be at least one eighth (1/8) inch smaller than the mainline. ( )

06. Placing, Condition, and Operation of Rigging. The placing, condition and operation of rigging shall be such as to ensure safety to those who will be working in the vicinity. ( )

07. Arrangement and Operation. Rigging shall be arranged and operated so that rigging or loads will not pound, rub, or saw against lines, straps, blocks, or other equipment. ( )

08. Line Hazards. ( )

a. Running lines and changed settings shall be made in a way to avoid bight of line hazards. ( )

b. Signals to operator shall be made before moving lines. ( )

09. Reefing. Reefing or similar practices to increase line pull shall be prohibited. ( )

10. Inspection of Rigging. ( )

a. A thorough inspection, by the operator or qualified person, of all blocks, straps, guylines, and other rigging shall be made before the rigging is placed in position for use and subsequently repeated every thirty (30) days for as long as the rigging is in position for use. Each rigging inspection shall be documented and kept onsite for review. ( )

b. This inspection shall include an examination for damaged, cracked or worn parts, loose nuts and bolts, lubrication, condition of straps and guylines. ( )

c. The repairs or replacements necessary for safe operation shall be made before rigging is used. ( )

352. GUYLINES.

01. General Requirements. ( )

a. Guylines shall be of plow steel or equivalent, and in good condition. ( )

b. Guylines shall be provided in sufficient number, condition and location to develop stability and strength equivalent to the breaking strength of any component part of the rigging or equipment. ( )

c. Guylines shall be fastened by means of shackles or hooks and slides. The use of loops or molles for attaching guylines is prohibited. The use of wedge buttons on guylines is prohibited. ( )

d. The "U" part of a shackle shall be around the guyline and the pin passed through the eye of the guyline. Pins shall be secured with molles, cotter-keys, or the equivalent. ( )

e. Guylines shall be kept tightened while equipment or rigging they support is in use. ( )

02. Anchoring Guylines. ( )

a. Stumps used for fastening guylines and skylines shall be carefully chosen as to position, height and strength. They shall be tied back if necessary. See Figures 352.02.a. and 352.02.b.

FIGURE 352.02.a.

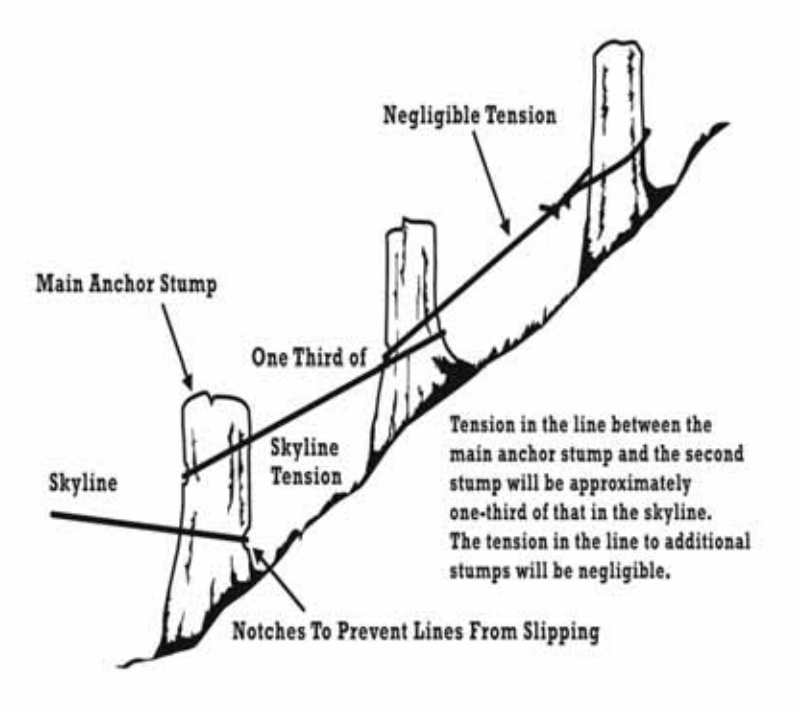
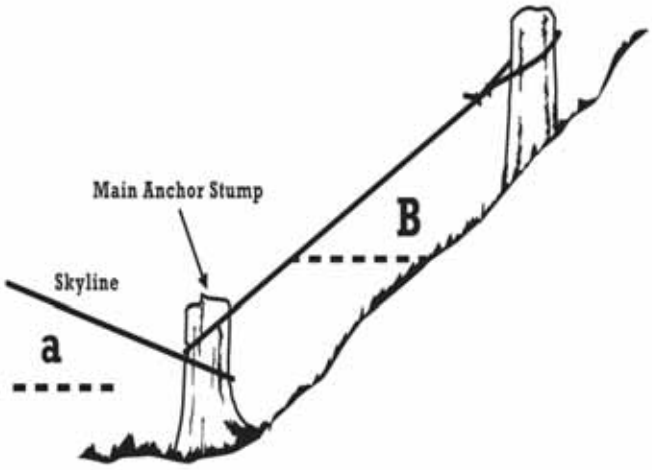


FIGURE 352.02.b.



Profile of a common two-stump anchor.

( )

b. Properly installed deadman anchors are permitted. Guylines shall not be directly attached to deadman anchors. Suitable straps or equally effective means shall be used. ( )

c. Stumps, trees and guyline anchors shall be inspected from time to time while an operation is in progress and hazardous conditions immediately corrected. ( )

d. Standing trees which will reach landing or work areas shall not be used for guyline anchors. ( )

e. Any guyline anchor tree that can reach the landing or work area shall be felled before using as an anchor. ( )

03. Effectiveness of Guys. ( )

a. Guys making an angle with the horizontal greater than sixty (60) degrees will be considered less than fifty percent (50%) effective. For the effectiveness of other angles see Table 352.03.a.

TABLE 352.03.a.

Degree	Effectiveness
60 to 45	50% to 75%
45 to 30	75% to 85%
30 to 10	85% to 95%

( )

b. For the effectiveness of guys according to the number of guys and their spacing, see Table 352.03.b.

TABLE 352.03.b.

No. of Guys Equally	Guys Most Effective When Pull Is:	Guys Will Support Strain Equal To The Following:
3	Opposite 1 guy	100% of strength of 1 guy
4	Halfway between 2 guys	140% of strength of 1 guy
5	Opposite 1 guy or halfway between 2 guys	160% of strength of 1 guy
6	Opposite 1 guy or halfway between 2 guys	200% of strength of 1 guy
7	Opposite 1 guy or halfway between 2 guys	225% of strength of 1 guy
8	Halfway between 2 guys	260% of strength of 1 guy
9	Opposite 1 guy or halfway between 2 guys	290% of strength of 1 guy
10	Opposite 1 guy or halfway between 2 guys	325% of strength of 1 guy

( )

04. Minimum Guyline Requirements. A minimum of four (4) top guys are required on any portable spar tree used for yarding, swinging, loading or cold-decking. ( )

353. LINES, SHACKLES AND BLOCKS.

01. General Requirements. ( )

a. All lines, shackles, blocks, etc., should be maintained in good condition and shall be of sufficient size, diameter and material to withstand one and one half (1 1/2) times the maximum stress imposed. ( )

b. Wire rope or other rigging equipment which shows a fifteen percent (15%) reduction in strength shall be replaced. ( )

02. Splices. ( )

a. Two (2) lines may be connected by a long splice, or by shackles of patent links of the next size larger than the line where practical. ( )

b. A safe margin of line must be used for making long splices. See Table 353.02.b.

TABLE 353.02.b.

Rope Diameter	Unraveled	Total Length
3/8"	**8'**	**16'**
5/8"	**13'**	**20'**

TABLE 353.02.b.		
Rope Diameter	**Unraveled**	**Total Length**
3/4"	**15'**	**30'**
7/8"	**18'**	**36'**
1"	**20'**	**40'**

( )

03. Wire Rope Clips or Clamps. ( )

a. Clips should be spaced at least six (6) rope diameters apart to achieve maximum holding power. See Table 353.03.a.

TABLE 353.03.a.		
Diameter of Rope	**Number of Clips**	**Required Space Between Clips**
1-1/2-inch	8	10 inches
1-3/8-inch	7	9 inches
1-1/4-inch	6	8 inches
1-1/8-inch	5	7 inches
1- inch	5	6 inches
7/8-inch	5	5-1/4 inches
3/4-inch	5	5-1/2 inches
3/8 to 5/8-inch	4	3 inches

( )

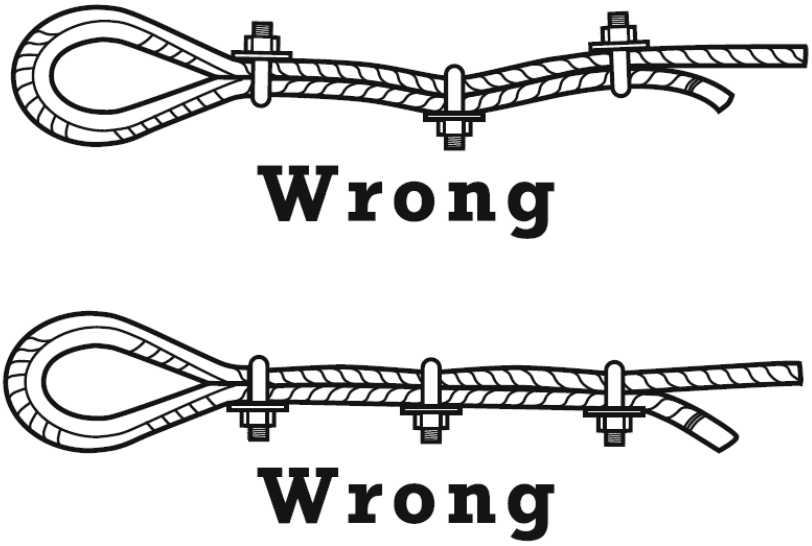
b. Clips should always be attached with the base or saddle of the clip against the longer or "live" end of the rope. See Figure 353.03.b. This is the only approved method.

FIGURE 353.03.b.

( )

c. Do not reverse the clips or stager them. See Figure 353.03.c. Otherwise the "U" bolt will cut into the live rope when the load is applied.

FIGURE 353.03.c.



( )

d. After the rope has been used and is under tension, the clips should again be tightened to take up any looseness caused by the tension reducing the rope diameter. Remember that even when properly applied a clip fastening has only about ninety percent (90%) of the strength of the rope and far less than that when rigged improperly. ( )

e. U-bolt wire rope clamps must not be used to form eyes on running lines, skylines, machine guylines, or straps. ( )

04. Blocks. All blocks must be of steel construction or of material of equal or greater strength and so hung that they will not strike or interfere with other blocks or rigging. ( )

05. Pins. All pins in blocks shall be properly secured by keys of the largest size the pin hole will accommodate ( )

06. Shackles. ( )

a. Spread in jaws of shackles shall not exceed by more than one (1) inch the size of yoke or swivel of the block to which it is connected. ( )

b. All shackles must be made of forged steel or material of equivalent strength and one (1) size larger than the line it connects. ( )

07. Cable Cutting. Cable cutters, soft hammers, or a cutting torch shall be available and used for cutting cables. Eye protection must be used when cutting cable. ( )

08. Damaged or Worn Wire Rope. Worn or damaged wire rope creating a safety hazard shall be taken out of service or properly repaired before further use. ( )

354. -- 400. (RESERVED)

SUBCHAPTER I – CANOPY AND CANOPY CONSTRUCTION FOR LOGGING EQUIPMENT
(Rules 401 - 450)

401. GENERAL REQUIREMENTS.

01. Driver Protection Guard. ( )

a. A substantial metal guard for the protection of the driver shall be installed on every piece of equipment, where exposed to overhead hazards. ( )

b. This guard shall be strongly constructed to afford adequate protection for the driver against overhead hazards. ( )

c. This guard shall be of sufficient width and height so that it will not impair the movements of the driver or prevent his immediate escape from the equipment in emergencies. ( )

d. This guard shall be of open construction to allow the driver all the visibility possible. ( )

02. Canopy Framework. ( )

a. The canopy framework shall consist of at least two (2) arches, either transverse or longitudinal. ( )

b. If transverse, one (1) arch shall be installed at the rear of the equipment and the other at the center of the equipment. They shall be joined together by three (3) longitudinal braces, one (1) at the top and one (1) at each side of the arches. ( )

c. There shall be a shear or deflecting guard extending from the leading edge of the forward arch to the front part of the frame of the tractor or similar equipment. ( )

d. If longitudinal arches are used, they shall be extended from the rear of the tractor or equipment to the front frame of the tractor or equipment and each arch shall have an intermediate support located approximately at the dash so that ingress or egress will not be impeded. ( )

e. Regardless of the type of construction used, the fabrication and method of connecting to the tractor or equipment shall be of such design as to develop a strength equivalent to that of the upright members. ( )

03. Canopy Structure. The canopy structural framework shall be fabricated of pipe of the following size, or materials of equivalent strength, depending upon the gross weight of the tractor or similar equipment as equipped. Under twenty-eight thousand (28,000) lbs., two (2) inch double extra strong pipe (XXS); twenty-eight thousand (28,000) to fifty-eight thousand (58,000) lbs., three (3) inch double extra strong pipe (XXS); over fifty-eight thousand (58,000) lbs., four (4) inch double extra strong pipe (XXS). ( )

04. Gusset Plates or Braces. Gusset plates or braces shall be installed on the canopy framework so that the framework will withstand a horizontal pressure equal to twenty-five percent (25%) of the gross weight of the tractor or similar equipment, as equipped, when such pressure is applied to any vertical member at a point not more than six (6) inches below the roof of the canopy. ( )

05. Clearance Above the Deck. The clearance above the deck of the tractor or similar equipment at points of egress shall be not less than fifty-two (52) inches and the clearance above the driver's seat shall be of such height as will allow sufficient clearance above the driver's head. ( )

06. Overhead Covering. The overhead covering on the canopy structure shall be of not less than three-sixteenth (3/16) inch steel plate except that the forward eighteen (18) inches may be made of one quarter (1/4) inch woven wire having not more than one (1) inch mesh. ( )

07. Rear Covering. ( )

a. The opening in the rear of the structure shall be covered with one quarter (1/4) inch woven wire having not less than one and one half (1 1/2) inch or more than two (2) inch wire mesh. This covering shall be affixed to the structural members so that ample clearance will be provided between the screen and the back of the operator. ( )

b. Structural members shall present smooth, rounded edges and the covering shall be free from projections which would tend to puncture or tear flesh or clothing. ( )

08. Pin Connections. ( )

a. Pin connections are recommended for joints in the structural frame and especially at connections to the tractor frame or similar equipment frame. ( )

b. Gusset plates shall be installed at each place where individual pieces of pipe are joined. ( )

09. Sideguards. When practical, sideguards shall be installed to protect the operator from hazards. ( )

402. TRACTORS AND SIMILAR LOGGING EQUIPMENT.

01. Operating Condition. ( )

a. The general operating condition of a tractor or equipment shall be sufficient to ensure the safety of the driver and other workmen. ( )

b. An operating manual shall be readily available in either print or electronic format for each piece of machinery. ( )

02. Guards. All guards shall be kept in place and in good repair at all times when the tractor or similar equipment is used. ( )

03. Repairs or Adjustments. Repairs or adjustments to clutches, frictions, or other parts of equipment which may cause hazardous movement of equipment shall not be done while engines are running. ( )

04. Blades or Similar Equipment. ( )

a. Blades or similar equipment shall be blocked or otherwise securely supported when making repairs or performing other work around such equipment when they are elevated from the ground. ( )

b. Equipment under repair or adjustment should be tagged out. ( )

05. Brakes and Steering. ( )

a. All equipment shall be equipped with a braking system capable of stopping and holding the maximum load on all grades at all times. ( )

b. Any defect found in the braking system or steering devices of any equipment used in skidding or yarding operations shall not be used until repaired or replaced. ( )

06. Starting of Equipment. Equipment shall be started (cranked) only by the operator or other experienced persons. ( )

07. Seatbelts. ( )

a. Seatbelts shall be installed on all tractors and mobile equipment having roll-over protection or in

accordance with a design by a professional engineer which offers equivalent employee protection. ( )

b. Seatbelts shall be used when operating any machine equipped with Roll Over Protection Structure (ROPS), Falling Object Protection Structure (FOPS), or overhead guards. ( )

08. Pin Connections. ( )

a. Pin connections are recommended for joints in the structural frame and especially at connections to the tractor frame or similar equipment frame. ( )

b. Gusset plates shall be installed at each place where individual pieces of pipe are joined. ( )

09. Sideguards. When practical, sideguards shall be installed to protect the operator from hazards. ( )

403. -- 450. (RESERVED)

SUBCHAPTER J – SKIDDING AND YARDING
(Rules 451 - 500)

451. SKIDDING AND YARDING.

01. General Requirements. ( )

a. All personnel shall wear approved head protection and proper clothing at all times in skidding and yarding. ( )

b. Getting on or off moving equipment is strictly prohibited. ( )

c. Equipment operators shall move rigging only upon the signal of an authorized person. ( )

d. Workers shall at all times watch for and protect themselves and their fellow workers from side-winders, rolling logs, up ending logs, snags, and other hazards caused by the movement of equipment, logs and/or lines. ( )

e. Chokers should be placed near, but not closer than two (2) feet, from the ends of logs if possible. ( )

f. Choker holes shall be dug from the uphill side of a log if there is any danger of its rolling. ( )

g. Knots shall not be used to connect separate lengths of chain or cable. ( )

h. Chaser (hooker) shall not unhook logs (trees) until rigging has stopped and the equipment operator is aware of his location. ( )

i. Riding on drag or logs or any part of equipment used in skidding and yarding except in the area of the driver's seat is prohibited. ( )

j. A tool handle, stick, iron bar, or similar object shall be used in guiding lines onto drums. Guiding lines with hands is prohibited. ( )

k. Make sure all personnel are in the clear before skidding turn, drag, log, or tree into landing. ( )

l. All personnel shall keep out of the bight of line and clear of running lines. ( )

m. Logs shall not be swung over personnel. ( )

n. Knot bumping should be done before a log is loaded. ( )

452. CABLE YARDING.

01. Safety A. Personnel shall not ride hooks, lines, rigging, or logs suspended in the air or being moved. ( )

02. Safety B, Personnel shall not hold on to haywire, running lines, drop lines, or chokers as an assist when walking uphill. ( )

03. Safety C. Personnel shall not work in the bight of lines under tension. ( )

04. Safety D. Personnel shall be "in the clear" before any signal to move any lines is given. ( )

05. Safety E. All swing yarders shall have the outer swing radius marked with hi-vis tape or cones while skidding is in progress. No tools or supplies may be kept inside that radius outside the machine unless in a locked box. No employee may get inside that radius without first notifying the operator. ( )

453. (RESERVED)

454. WIRE ROPE.

01. General Characteristics. Wire rope comes in many grades and dimensions, and every rope has its own characteristics with regard to strength and resistance to crushing and fatigue. A larger rope will outlast a smaller rope of the same materials and construction, used in the same conditions, because wear occurs over a larger surface. Similarly, a stronger rope will outlast a weaker rope, because it performs at a lower percentage of its breaking strength, with reduced stress. ( )

02. Wire Rope Terms. Common grades of wire rope include extra improved plow steel (EIPS) and swaged powerflex, among others. The following terms are commonly used for wire rope: ( )

a. Abrasion Resistance. Ability of outer wires to resist wear. Abrasion resistance is greater with larger wires. ( )

b. Core. The foundation of a wire rope which is made of materials that will provide support for the strands under normal bending and loading conditions. A fiber core (FC) can be natural or synthetic. If the core is steel, it can be a wire strand core (WSC) or an independent wire rope core (IWRC). ( )

c. Crushing Resistance. Ability of the rope to resist being deformed. A rope with an independent wire core is more resistant to crushing than one with a fiber core. ( )

d. Die-form Line. Made from strands that are first compacted by drawing them through a drawing die to reduce their diameter. The finished rope is then swaged or further compressed. ( )

e. Fatigue Resistance. Ability of the rope to withstand repeated bending without failure (the ease of bending a rope in an arc is called its "bendability"). Fatigue resistance is greater with more wires. ( )

f. Strength. Referred to as breaking strength, usually measured as a force in pounds or tons. The breaking strength is not the same as the load limit, which is calculated as a fraction of the breaking strength to ensure safety. ( )

g. Swaged Line. Manufactured by running a nominal-sized line through a drawing die to flatten the outer crown and thus reduce the rope diameter. This compacted rope allows for increased drum capacity and increased line strength. ( )

03. Typical Wire Rope Specifications. The table below lists a few examples of wire-rope breaking strengths. ( )

TABLE 454.03 – Typical Wire Rope Specifications

6x26 Improved Plow Steel			6x26 Swaged		Swaged Compact-Strand	
Diameter (inches)	Weight (lbs/ft)	Breaking Strength (tons)	Weight (lbs/ft)	Breaking Strength (tons)	Weight (lbs/ft)	Breaking Strength (tons)
1/2	0.46	11.5	0.6	15.2	0.63	18.6
9/16	0.59	14.5	0.75	19	0.78	23.7
5/8	0.72	17.9	0.93	23.6	1.01	28.5
11/16			1.10	28.8	1.18	35.3
3/4	1.04	25.6	1.37	34.6	1.41	42.2
13/16			1.56	39.6	1.63	49.3
7/8	1.42	34.6	1.83	46.5	1.91	56.0
15/16			1.95	53.3	2.20	66.1
1	1.85	44.9	2.42	60.6	2.53	73.7
1-1/8	2.34	56.5	2.93	75.1	2.97	92.9
1-1/4	2.89	69.3	3.52	92.8	3.83	112.1
1-3/8	3.5	83.5	4.28	108.2	4.62	128.6

Source: Cable Yarding Systems Handbook. 2006. Worksafe BC. Table lists typical breaking strengths. See manufacturer's specifications for specific lines. ( )

04. Synthetic Rope. High-tensile strength synthetic lines are considerably lighter than standard wire rope; however, some lines are dimensionally as strong as standard wire rope. Accordingly, high-tensile strength synthetic lines are permitted to be used in appropriate logging applications, including as substitutes for brush straps, tree straps, tail and intermediate support guylines, guyline extensions, skyline extensions, and haywire. Manufacturers' standards and recommendations for determining usable life or criteria for retirement of such lines shall be followed. Personnel shall examine the lines for broken or abraded strands, discoloration, inconsistent diameter, glossy or glazed areas caused by compression and heat, and other inconsistencies. Rope life is affected by load history, bending, abrasion, and chemical exposure. Most petroleum products do not affect synthetic ropes. ( )

05. Inspection and Care. ( )

a. Wire rope shall be inspected daily by a qualified individual and repaired or taken out of service when there is evidence of any of the following conditions: ( )

i. Twelve and five tenths percent (12.5%) of the wires are broken within a distance of one (1) lay.

( )

ii. Evidence of chafing, sawing, crushing, kinking, crystallization, bird-caging, corrosion, heat damage, or other damage that has weakened the rope structure. ( )

b. Qualified personnel shall closely inspect those points subject to the most wear, including the knob ends of lines, eye splices, and those sections of line that most often run through blocks or carriages. If there is doubt about the integrity of the line, it is far safer to replace a suspect line, or cut out and resplice a defective area, than risk a failure during operation. Evaluation of the load-bearing yarder lines shall be stringent. A qualified person shall also inspect all other lines used on site and remove any that are unsafe. ( )

06. Additional Precautions. The following precautions shall also be observed: ( )

a. Ensure the working load limit for any line is adequate for the intended use. ( )

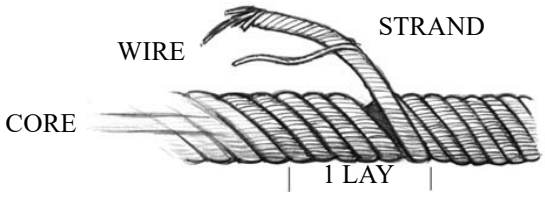
b. The manufacturer's specifications with regard to assigned breaking strength shall be followed. Such specifications as determined by engineering test results should factor the grade of the wire, number of strands, number of wires per strand, filler wire construction, lay pattern of the wires, and the diameter of the line. ( )

07. Safety Factor. Operators shall follow the manufacturer's specifications in determining load limits. The working load limit is a fraction of a line's breaking strength – a factor of three (3), or one-third (1/3) the breaking strength, is commonly used as a safety factor for running and standing lines, when workers are not exposed to breaking lines or loads passing overhead. A safety factor of three (3) is commonly used to determine the working load limit for a standing or running line. A standard six (6) x twenty-six (26) IWRC wire rope with a diameter of one (1) inch has a breaking strength of approximately forty-five (45) tons – divide by three (3) – equals fifteen (15) tons working load limit. ( )

08. Wire Labeling. ( )

a. The elements of a typical wire rope are labeled, for example, six (6) x twenty-five (25) FW PRF RL EIPS IWRC. The label indicates a six (6)-strand rope with twenty-five (25) wires per strand (six (6) x twenty-five (25)), filler-wire construction (FW), strands pre-formed in a helical pattern (PRF), laid in a right-hand lay pattern (RL), using an extra-improved plow steel (EIPS) grade of wire, and strands laid around an independent wire rope core (IWRC). See figure 013.08-A for proper labeling of wire rope. ( )

FIGURE 454.08.a.



( )

b. Out of Service Standard Example. A six (6) x twenty-five (25) IWRC wire rope = six (6) strands in one (1) lay with twenty-five (25) wires per strand = one hundred fifty (150) wires. The rope must be taken out of service when twelve and five tenths percent (12.5%), or one-eighth (1/8), of the wires are broken within the distance of one (1) lay = one hundred fifty (150) divided by eight (8) = eighteen and seventy-five one hundredths (18.75), or nineteen (19) broken wires. ( )

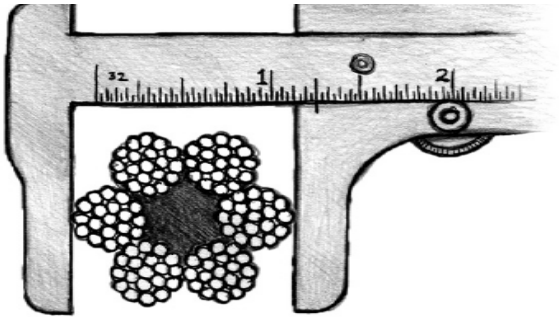
09. Wire Line Life. Table 454.09 provides the allowable life of a line in million board feet in accordance with line size and use. Figure 454.09.a. illustrates both the correct and incorrect manner in which to measure line size (diameter). ( )

TABLE 454.09
LINE LIFE BY WOOD HAULED

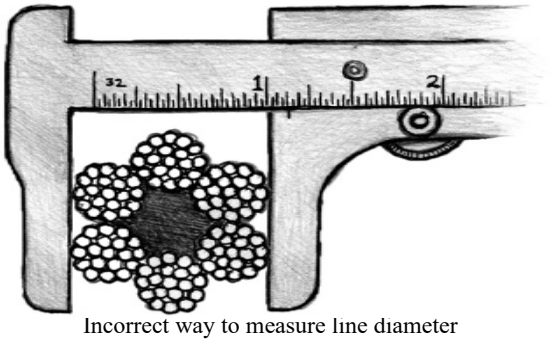
System	Use	Line Size (inches)	Line Life (million board feet)
Standing Sky-line	Skyline	1-3/4	20-25
		1-1/2	15-25
		1-3/8	8-15
	Mainline	1 to 1-1/8	15-20
		1	10-15
	Haulback	3/4 to 7/8	8-12
Live Skyline	Skyline	1-1/2	10-20
		1-3/8	8-15
		1	6-10
	Mainline	1	10-15
		3/4	8-12
		5/8	8
	Haulback	3/4 to 7/8	8-12
		1/2	6-10
	Dropline	7/16	5-8
High Lead	Mainline	1-3/8	8-15
		1-1/8	6-12

Source: Willamette Logging Specialist's Reference by Keith L McGonagill. 1976. Portland, OR: Willamette National Forest. Calculations of line life refer to EIPS 6x21 wire rope for the skyline, and EIPS 6x26 for other lines. Figures will be different for other classes of wire rope. ( )

FIGURE 454.09.a.



Correct way to measure line diameter



Incorrect way to measure line diameter

( )

10. Dynamic Loads. Operators shall consider high dynamic loads when calculating safe working limits of wire ropes. Wire ropes are often subjected to high dynamic loads, which greatly multiply the force on a line and may exceed the safe working limit. Even a split second of time over the limit can lead to premature failure of a line. Typical dynamic loads occur when a turn hits a stump, a turn comes down off of the back hillside to full suspension, or when excessive force is applied to pulling a turnout of its bed. A high dynamic load or a sudden shock load that exceeds the working limit may not result in immediate failure, but rope strands may stretch and weaken, and may fail at a later time. ( )

11. Other Common Wire Rope Considerations. ( )

a. Wire Rope Stretching and Line Diameter. A stretched wire rope has a reduced diameter. Operators shall check for stretched lines by measuring the diameter, particularly on older lines and any line used in stressful situations. ( )

b. Older Wire Rope. Standing lines and guylines are often kept in service for multiple years (four (4) to five (5), and as long as ten (10) years in some instances) without exhibiting any obvious signs of excessive wear other than rust. Operators shall check date stamps of wire rope and evaluate line life. Operators shall also inspect the core of older lines periodically for a fractured or dry core, which could indicate other deficiencies such as broken wires, excessive wear, or line deformation. ( )

c. Hard Use. The life of a wire rope is also affected by hard use. Line life can be measured by the volume of wood hauled (see Table 459.09). Line life is reduced when a line exceeds its elastic limits, is heavily shocked, or rubbed against rocks or other lines. As a line wears, the safe working load limit shall be lower and the payload adjusted appropriately. ( )

d. Wire Rope endurance and elastic limits. Working within the endurance and elastic limits of lines can help preserve line life. The following principles shall be observed when evaluating the integrity and safe use of

wire rope: ( )

i. The "endurance limit" for all lines is fifty percent (50%) of the breaking strength. If wire rope tensioning regularly exceeds the endurance limit, the life of the line is reduced through fatigue. ( )

ii. The "elastic limit" for all lines is sixty to sixty-five percent (60-65%) of the breaking strength. When a wire rope is loaded to its normal safe working limit, the line stretches, but then returns to its original size when the load is released. If a load increases past the elastic limit through prolonged exertion or repeated stress, the line will stretch and stay stretched, resulting in a permanent reduction in the breaking strength. ( )

e. Lubrication and Abrasion. Wire rope is lubricated in the factory to reduce internal friction and corrosion, and prolong the life of the rope. Heat from friction causes the internal lubricant to deteriorate. Friction occurs when the rope stretches under load, particularly in places where it bends around sheaves or other objects. An improperly lubricated line can pick up particles of dirt and sand that will increase abrasion. Accordingly, operators shall: ( )

i. Check for and ensure the proper lubrication of all lines and wire rope, following the manufacturer's instructions. Commercial wire rope lubricants are available. ( )

ii. Carefully inspect lines for faults in areas where dust and sand may collect. ( )

iii. Store all wire rope and lines off the ground. ( )

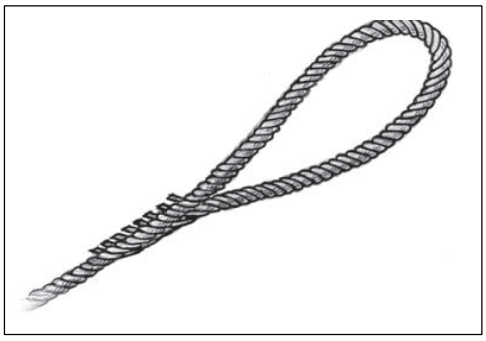
12. Line Connections. ( )

a. Inspection. Operators shall regularly inspect shackles, hooks, splices, and other connecting equipment for damage and wear, as well as ensure the connectors are the correct type and size for the line and intended use. ( )

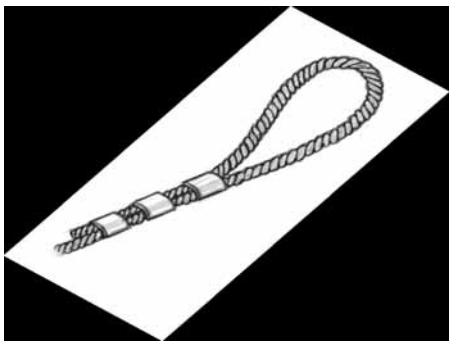
b. Wire Splicing. Splices are used to form an eye at the end of a line, extend the length of a line, or repair a broken or damaged line. The splicing of wire rope requires special skill and shall only be performed under the supervision of a competent person with using the proper tools. Reference materials are available with detailed instructions for numerous types of splices. Individuals splicing wire shall always wear appropriate eye protection while splicing or assisting with a splicing procedure. ( )

c. The logger's eye splice and three (3)-pressed eye are the most common methods to form an eye for use as a skyline terminal. See Figure 454.12.c. The spliced eye is approximately eighty percent (80%) efficient. A three (3)-pressed eye can reach ninety percent (90%) line strength. The pressed eye is typically performed at the rigging shop. Spliced eyes may be placed in the field, but may require additional time to install. ( )

FIGURE 454.12.c.



THE LOGGER'S EYE SPLICE



THREE-PRESSED EYE

( )

d. When Flemish (Farmers, Rolled) eye splices are used on load-bearing lines, the strand ends must be secured by: ( )

i. Hand tucking each strand three (3) times; or ( )

ii. Applying a compression (pressed-eye) fitting. ( )

e. Guyline Care. Guylines are a vital link in holding up a tower. Guyline extensions shall not be excessively moved around by dragging on the ground, or left on the ground for long periods of time as they will deteriorate faster. ( )

f. Guyline extensions must be connected by: ( )

i. A bell shackle using a safety pin to connect spliced eyes or pressed eyes; or ( )

ii. Poured nubbins (buttons) and a double-ended hook. ( )

g. Line Deformity. A line may deform where it loops around a shackle or pin, producing weakness that may result in line failure. A thimble in the loop protects the line. Thimbles may be used on standing lines, but not on running lines. Examples of the appearance of deformed lines and the use of thimbles in shackles are illustrated in Figure 454.12.g. ( )

FIGURE 454.12.g.

DEFORMED EYE

EYE WITH THIMBLE

( )

13. Shackles and Hooks. ( )

a. Hooks. Hooks shall be inspected to ensure that they have not sprung open. Ensure that shackles are positioned correctly to bear the load. Haywire swivels shall be inspected frequently, due to their susceptibility to wear rapidly. ( )

b. Shackle Safety. Proper bells or shackles shall be used to connect the guylines to the stumps, and the guyline lead blocks to the ring at the top of the tower. Connections shall have at least one and a half (1-1/2) times the strength of the guyline. The pins of the shackles must be secured to protect against dislodgement, and a nut and cotter key, or a nut and molly may be used for that purpose. The use of loops or mollies to attach guylines is prohibited. Examples of the appearance of some shackle equipment is illustrated in Figure 454.13.b.

FIGURE 454.13.b.

SHACKLE WITH SAFETY PIN

HAYWIRE SWIVEL

HAYWIRE HOOKS

( )

c. The following practices shall be observed in order to ensure the safe use of shackles: ( )

i. A shackle must have a rated breaking strength greater than the rated breaking strength of the lines attached to it, and the manufacturer's rated strengths to determine oversized requirements shall be used. Accepted industry standards shall be utilized and adhered to when determining the correct shackle size based on the type and nature of the logging operation being performed. Examples of the appearance of some shackle equipment for the purposes of proper selection is illustrated in Figure 454.13.c.i ( )

ii. Shackles with pins, and securing nuts with mollies or a cotter key shall be used on standing or overhead rigging. ( )

iii. Screw shackle pins shall not be used in any standing or overhead rigging. ( )

iv. Screw shackle pins, where allowed to be used, shall be tightened securely. ( )

v. Shackle pin mollies shall be rolled sufficiently and fit the pin hole fully. Mollies shall be tucked a minimum of three (3) times. ( )

vi. The shackle shall always be placed with the pin nearest to the yarder, so that in the event the shackle fails the least amount of hardware may be thrown at the yarder. ( )

vii. Replace shackles that are bent, broken, or show excess wear on the inner surfaces. Examples of the appearance of some damaged or non-conforming shackles are illustrated in Figure 454.13.c.vii. ( )

FIGURE 454.13.c.vii.

REPLACE SHACKLES THAT ARE BENT, BROKEN, OR SHOW EXCESS WEAR ON THE INNER SURFACES.

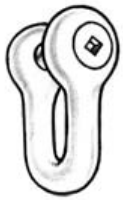
viii. Sleeve shackles or choker bells must be used when choked lines are permitted. ( )

FIGURE 454.13.c.i.

SLEEVE WITH KNOCKOUT PIN

BELL WITH KNOCKOUT PIN

SLEEVE WITH SAFETY PIN



FLUSH PIN STRAIGHT SIDE

( )

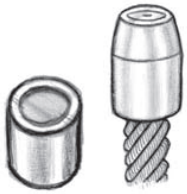
14. Knobs, Ferrules, and Eyes. ( )

a. Poured nubbins and a double-end hook are acceptable connectors in place of shackles in some instances. The use of quick nubbins (wedge buttons) as guylines and skyline end fittings is prohibited unless attaching guylines to guyline drums. Operators shall follow the manufacturer's recommendations when attaching sockets and similar end fastenings. ( )

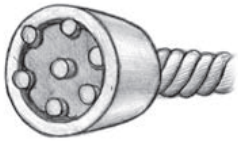
b. Poured nubbins achieve ninety-nine percent (99%) of line strength and may be used. Quick nubbins only achieve a maximum of sixty-five percent (65%) under ideal conditions, and accordingly operators shall consider whether they are appropriate for safe use in any given application. Pressed ferrule are not certifiable for strength, and shall not be used. Examples of the appearance of some knob, ferrule, and nubbin equipment are illustrated in Figure 454.14. ( )

c. Operators shall inspect knobs, ferrules, and eyes at cable ends for loose or broken wires, and corroded, damaged, or improperly applied end connections. Poured nubbins shall be date stamped.

FIGURE 454.14



BABBITED KNOB & PRESSED FERRULE



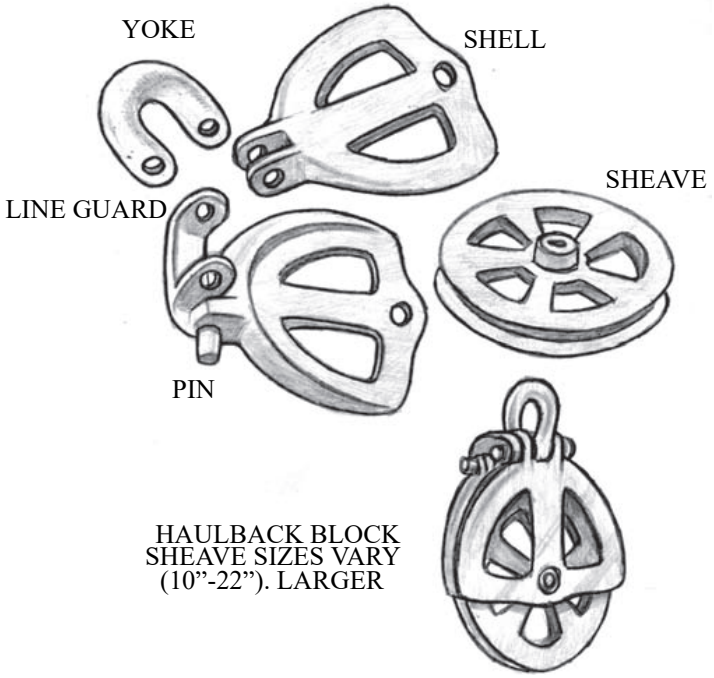
QUICK NUBBIN (WEDGE BUTTON)

( )

15. Brush Blocks. Brush blocks shall be thoroughly inspected for cracks, wear, or deterioration.

Operators shall closely examine the areas subject to the most wear, including bearings, sheave, frame, yoke, and pins. Defective parts shall be replaced immediately. Blocks shall be greased every time before each use.

FIGURE 454.15

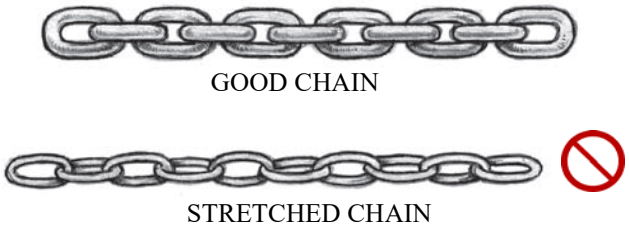


( )

16. Chains and Straps. Chains or straps shall always be sized and used correctly for the intended purpose. Determining which size to use may depend on various factors. Oversized trailer lift straps, for example, shall have a breaking strength equal to five (5) times the load to be lifted. Towing chains shall have a tensile strength equivalent to the gross weight of the towed vehicle. The manufacturer’s specifications or other appropriate reference materials shall always be consulted to ensure the right chain or strap is used for a task. ( )

a. Operators shall periodically inspect chains for damaged, worn, or stretched links. Chains with more than ten percent (10%) wear at the bearing surface shall be replaced. Operators shall periodically inspect straps, and examine them for broken wires or wear. Examples of the appearance of damaged and safe chains are illustrated in Figure 454.16.a.

FIGURE 454.16.a.



WORN CHAIN (INSIDE LINKS)

( )

455. TREE CLIMBING.

Loggers are often required to climb considerable heights to top trees or hang rigging on lift trees. All workers who may be exposed to fall hazards shall be specifically trained and equipped with fall protection. ( )

01. Rescue Plan. Before rigging any tree, the employer must develop rescue procedures, which includes identifying appropriate equipment, personnel, and training to perform a rescue in case a climber is injured or incapacitated in the tree. A second set of climbing gear and a person with climbing experience shall be readily available. Equipment and procedures that will support an injured climber's chest and pelvis in an upright position during a rescue shall be used. When an injured climber is wearing only a climbing belt, provisions must be made to prevent the climber from slipping through it; this may include using a rope to create an upper-body support system. Consideration should be made to replacing climbing belts with a climbing harness. ( )

02. Before Leaving the Ground. Employers shall check climbing equipment and immediately remove defective equipment from service. Personnel shall ensure that hardware and safety equipment is securely fastened before placing weight on the lanyard or life-support rope. All climbing knots shall be tied, dressed, and set prior to ascending. All personnel shall follow the recommendations of the manufacturer of the cordage with respect to the use of splices. ( )

03. Climbing Equipment. ( )

a. A climbing harness provides both pelvic and upper-body support, and may be a one (1)-piece, full-body harness, or any two (2)-piece design that meets industry standards. ( )

b. Climbing and life-support lines shall be conspicuous and easily identifiable. ( )

c. All lines and webbing used for life support shall have a minimum breaking strength of five thousand four hundred (5,400) pounds and may only be used for climbing. ( )

d. When a cutting tool is used in a tree, the climbing rope (lanyard) shall be a high-quality steel safety chain of three-sixteenths (3/16) inch size or larger, or a wire-core rope. ( )

e. A life-support rope evidencing excessive wear or damage or that has been subjected to a shock load shall be removed from climbing service. ( )

04. Climbing Operations. ( )

a. Ensure climbers are appropriately well-trained in climbing and in the use of all equipment to carry out assigned tasks. ( )

b. While climbing operations are underway, co-workers and others on the ground shall stay clear of potential falling objects. If co-workers must work directly below a climber, the climber shall stop any activity in which objects could be dropped or dislodged until the area below is cleared. Climbers shall provide warning whenever any material may be likely to fall or is dropped deliberately. Unsecured equipment, rigging, or material shall not be left in the tree. ( )

c. Yarding activity must cease within reach of a tree or guylines of a tree where a climber is working. Machinery may operate in reach of the climber to hoist rigging into the tree. In such circumstance the following shall apply: ( )

i. A spotter shall be utilized and yarding operations shall be performed with extra caution; ( )

ii. The machine operator and the spotter shall give the task their undivided attention; ( )

iii. Equipment that is nearby and which may be noisy, such as power saws, tractors, or logging machines shall be shut down if the noise interferes with signal communications with the climber; and ( )

iv. Lines attached to a tree in which a climber is working shall not be moved except on a signal from the climber. ( )

d. Tree climbers shall use a three (3)-point climbing system whereby three (3) points of contact must be firmly in place on a secure surface before moving to another point. Along with hands and feet, other points on the body, such as a hooked knee, can be considered a point of contact if it can support the full body weight. Additionally, the places of support must be secure, and climbers should use care to void unsound branches or stubs as a contact point. A lanyard around the tree secured to the safety harness or climbing belt on both ends constitute two (2) points of contact. ( )

e. Climbing without being secured to the tree is prohibited, except in conifers, when in the judgment of a qualified climber, the density of branches growing from the stem make attaching the lanyard more hazardous than simply climbing the tree. In such instances, the climber shall evaluate the tree farther up, and use attachments when it is safe to do so. ( )

05. Topping Trees. Only an experienced climber with experience felling trees shall top a tree. Cutters shall not cut when wind or other conditions make doing so hazardous. Standard safe felling procedures shall apply, with the additional following requirements: ( )

a. A chainsaw with a bar short enough to make both the face-cut and backcut easily from one side shall be used. ( )

b. Cutters shall determine the felling direction and ensure there are no obstructions. Consideration shall be given to the fact that an impact could cause violent movement in the tree being topped where the climber is perched. ( )

c. A safety chain shall be wrapped around the tree just below the cut to prevent the tree from splitting or slabbing down inside the climbing rope. ( )

d. The cutter shall ensure he is comfortable, and avoid any awkward cutting position. ( )

e. Exact cuts should be made. There is no escape route for the climber to get away from the stem to avoid kickback or a splintered hinge. When making horizontal side cuts, extra care shall be used to stay on the line of the backcut to avoid wood breaking away with the saw as the top falls. ( )

456. -- 500. (RESERVED)

SUBCHAPTER K – ROAD TRANSPORTATION
(Rules 501 - 550)

501. LOG TRUCK TRANSPORTATION.

01. General. The following requirements are supplemental to any Idaho law governing automobiles, trucks, tractors, trailers, and any combination of these units. If there are any discrepancies in the codes between this section and any federal or Idaho motor vehicle regulations pursuant to title 49, Idaho Code, applicable in the state of Idaho, such federal or other governmental regulations will govern. ( )

02. Stopping and Holding Devices for Log Trucks. ( )

a. Motor logging trucks and trailers must be equipped with brakes or other control methods which

will safely stop and hold the maximum load on the maximum grade. Air or vacuum brake lines shall be of the type intended for such use and shall have fittings which will not be interchangeable with water or other lines. ( )

b. Brake Test - A brake test shall be made before and immediately after moving a vehicle. Any defects shall be eliminated before proceeding. ( )

03. Lighting Equipment Required. ( )

a. Motor vehicles used on roads not under the control of the Idaho Transportation Board, counties or cities, shall have equipment necessary for safe operation, such as head, tail, and stop lights. ( )

b. Such lights shall be used during clearance periods of reduced visibility. ( )

04. Safe Operating Requirements. ( )

a. The driver shall do everything reasonably possible to keep his truck under control at all times and shall not operate in excess of a speed at which he can stop the truck in one-half (1/2) the distance between him and the range of unobstructed vision. ( )

b. The driver shall take into consideration the condition of the roadway, weather factors, curves, grades and grade crossings, the mechanical condition of his equipment, and other relevant factors. ( )

c. The driver shall clear rocks from between dual tires before driving on multi-lane roads. ( )

d. A daily inspection shall be made of trucks and trailers with particular attention to steering apparatus, brakes, boosters, brake hoses and connections, reaches, and couplings. Any defects found shall be corrected before equipment is used. ( )

05. Stakes, Bunks, or Chock Blocks. All stakes and bunks, installed on log trucks and trailers, together with the means provided for securing and locking the stakes in a hauling position, shall be designed and constructed of materials of such size and dimensions that will withstand a pressure of fifteen thousand (15,000) pounds applied outward against the tops of the stakes, and, or extensions when used, without yield or permanent set resulting in the stakes, bunks or the means provided for securing and locking the stakes.

NOTE: Test Procedure - A test pressure of fifteen thousand (15,000) pounds is applied to the top of one (1) stake, using the top of the stake opposite as a base for applying pressure. Bunk is not to be secured to floor or other base except in a manner similar to that used to mount it to truck or trailer. Stakes must return to normal upright position at end of test and stakes and all component parts examined and checked with original specifications. If no yield results in any part, the design and construction may be considered as meeting code requirements. ( )

06. Stake Extensions. ( )

a. Stake extensions shall not be used unless all component parts of the bunking system are of sufficient size and strength to support the added stresses involved. ( )

b. Truck drivers shall report missing or broken stake extensions to the proper authority. ( )

07. Stake and Chock Tripping Mechanisms. Stakes and chocks that trip shall be constructed in such a manner that the tripping mechanism, which releases the stake or chocks, is activated at the opposite side of the load from the stake being tripped. ( )

08. Linkage for Stakes or Chocks. ( )

a. The linkage used to support the stakes or chock must be of adequate size and strength to withstand the maximum imposed impact lead. ( )

b. "Molly Hogans" or cold shuts are prohibited in chains or cable used for linkage. ( )

09. Notify Engineer When Around Truck. ( )

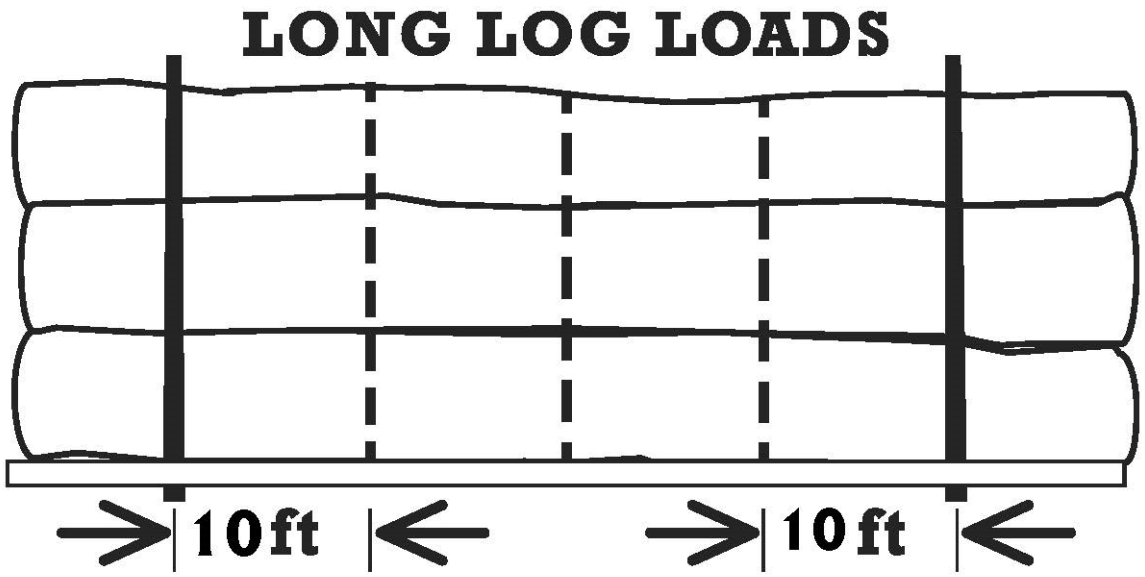
a. Persons shall not walk along side of or be underneath any truck being loaded. ( )

b. Prior to performing any duties, such as releasing bunk locks, placing or removing compensating pin, scaling logs, reading scale, chopping limbs or making connections, persons shall notify the loading engineer of their intentions and be acknowledged. ( )

10. Number of Wrappers Required. ( )

a. Each unit used for hauling logs longer than twenty six (26) feet, shall have the load secured by a minimum of three (3) wrappers. Wrappers shall be placed in positions that effectively secure the load. One (1) wrapper shall be placed within ten (10) feet of each bunk. See Figure 501.10.a.

FIGURE 501.10.a.

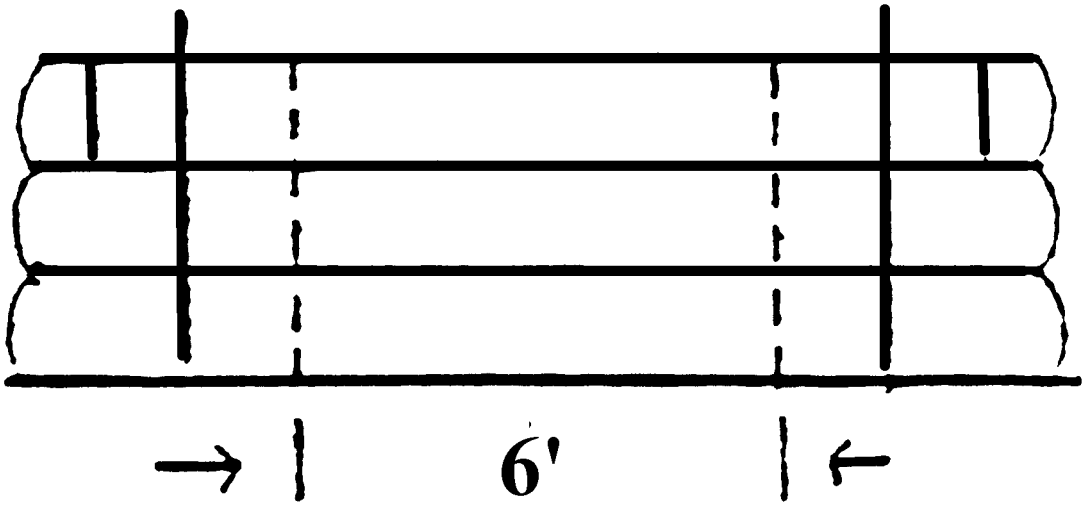


( )

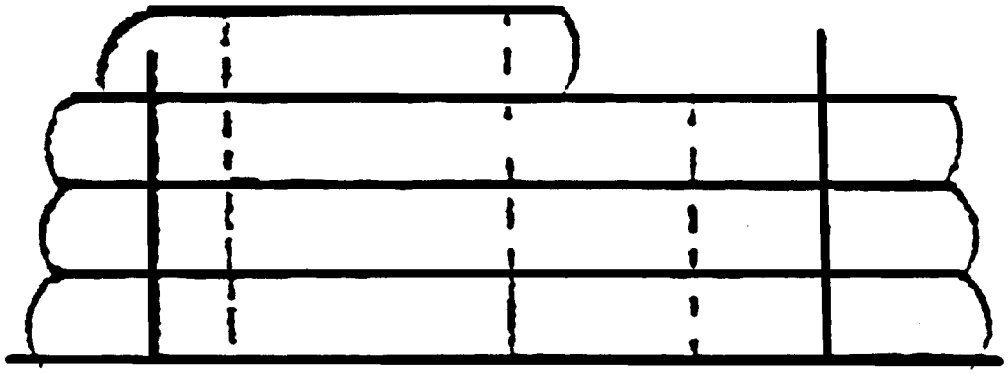
b. All exposed outside logs shall be secured by a minimum of two rappers. See Figure 501.10.b.

FIGURE 501.10.b.

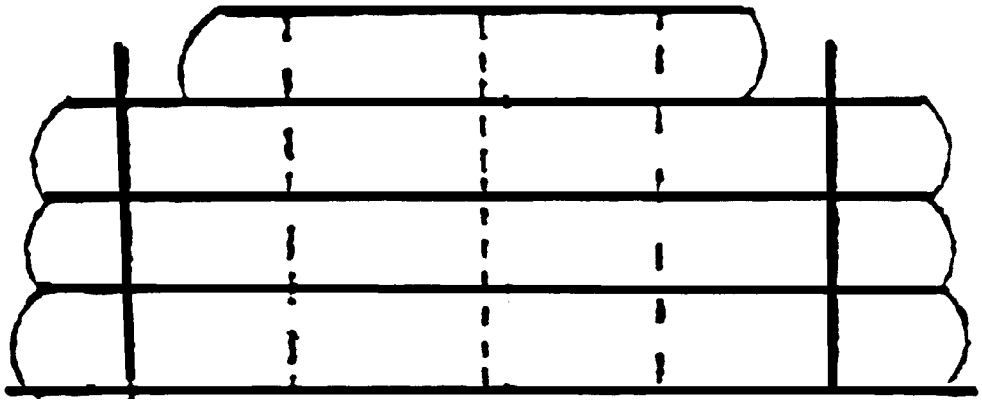
SHORT LOG LOADS



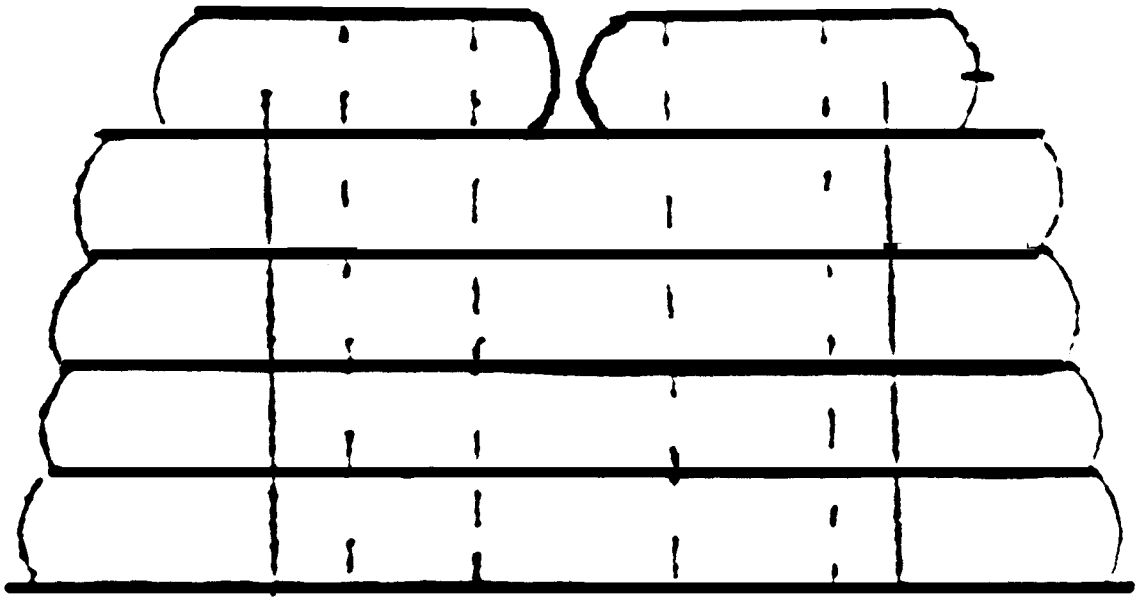
LONG LOG LOAD WITH SHORT LOGS IN REAR OR IN FRONT



LONG LOG LOAD WITH SHORT LOGS IN CENTER



LONG LOG LOAD WITH SHORT LOGS BUTTED



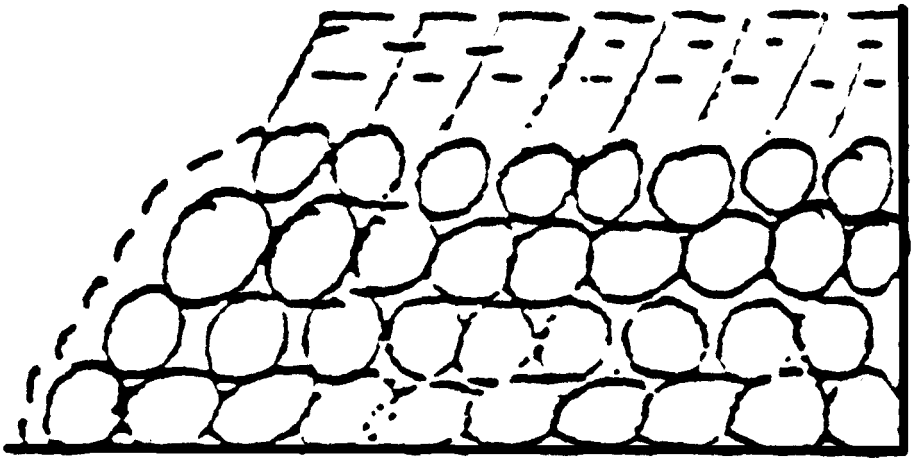
( )

11. Requirements for Crosswise Loaded Trucks. ( )

a. When loads of short logs are loaded crosswise, the logs shall be properly contained by use of stake or chock blocks and shall be secured by a minimum of two (2) wrappers. (See Figure 501.11.a.)

FIGURE 501.11.a.

CROSSWISE LOADED TRUCK



( )

b. Binders shall be securely fastened to the vehicle. ( )

12. Construction of Wrappers and Binders. ( )

a. Cables shall have a spliced eye or swaged fittings. ( )

b. "Molly Hogans" or cold shuts are prohibited to make splices or connections. ( )

c. Each wrapper shall have a minimum breaking strength of not less than fifteen thousand (15,000) pounds. ( )

d. Binders must be stamped with a working load limit of four thousand (4,000) pounds or greater. ( )

13. Binder Placement Requirements. ( )

a. Binders shall be placed in a manner whereby they will be released on the side opposite the brow log, or on the side where the unloading equipment operator can see the binders. ( )

b. Truck drivers shall be required to stop vehicles, dismount, check and tighten loose load binders, either just before or immediately after leaving a private road to enter the first public road they encounter. ( )

14. Precautions When Placing or Removing Binders and Wrappers. ( )

a. Binders and wrappers shall remain on the load until an approved safeguard has been provided to prevent logs from rolling off the side of truck where binders are being released. ( )

b. At least one (1) wrapper shall remain secured while relocating or tightening other binders. ( )

15. Binders and Wrappers to Be Placed Before Leaving Landing Area. Binders and wrappers shall be placed and tightened around the completed load before shifting the load for proper balance. Each load must have all required wrappers placed and secured at the loader before the truck is moved. If it is unsafe to do so, the truck may be moved to the nearest safe place in sight of the loader. ( )

16. Adequate Reaches Required. ( )

a. Log trailers must be connected to tractors by reaches of a size and strength to withstand all imposed stresses. ( )

b. Spliced reaches shall not be used. ( )

c. Documented reach inspections shall be performed annually. ( )

17. Proper Lay of Logs in Stakes or Bunks. ( )

a. The method of loading shall be such that the logs in any tier or layer unsecured by stakes or cheese blocks shall have their centers inside of the centers of the outer logs of the next lower tier or layer so that the load is stable without the aid of binders. ( )

b. Logs shall be well saddled without crowding so that there will be no excessive strain on the wrappers or stakes. ( )

c. No more than one half (1/2) of any log shall extend above the stakes unless properly and securely saddled. ( )

d. Bunk logs shall extend not less than twelve (12) inches beyond the bunk, with the exception of non-oscillating bunks. ( )

18. Traffic Travel on Right Side of Road Except Where Posted. All trucks shall keep to the right side of the road, except where road is plainly and adequately posted for left side traveling. ( )

19. Towing of Trucks. When trucks must be towed on any road, the person guiding the vehicle being towed shall, by prearranged signals, govern the speed of travel. ( )

20. Scaling and Branding. When at the dump or reload and where logs are scaled or branded on the truck, the logs shall be scaled or branded before the wrappers are released. ( )

21. Metal Parts Between Bunk and Cab to Be Covered. Suitable material shall be used on treading surfaces between the bunk and cab to prevent persons from slipping on the metal parts. ( )

22. Bunks to Be Kept in Good Condition and Repair. ( )

a. Log bunks or any part of bunk assembly bent enough to cause bunks to bind shall be straightened. ( )

b. Bunks shall be sufficiently sharp to prevent logs from slipping. ( )

23. Following Other Vehicles. ( )

a. A vehicle not intending to pass shall not follow another vehicle closer than one hundred fifty (150) feet. ( )

b. Passing shall be done only when it can be done safely. The passing vehicle shall consider all factors which may be essential, such as condition of the roadway, width of the road, and distance of clear visibility ahead. ( )

24. Reaches to Be Clamped When Towing Unloaded Trailer. A positive means, in addition to the clamp, shall be installed on the reach of log truck trailers when the trailers are being towed without a load. ( )

25. Inserting of Compensating Pin. ( )

a. Persons shall never enter the area below suspended logs or trailers. ( )

b. At dumps where the load must remain suspended above the bunks until the truck is moved away and when the trailer is the type with a compensating pin in the reach, a device shall be installed that will allow the trailer to be towed away from the danger area. ( )

26. Safety Chains. ( )

a. All trailers shall be secured with a safety chain, or chains, which connect the frame of the truck assembly to the trailer unit. ( )

b. The chains shall be capable of holding the trailer in line in case of failure of the hitch assembly. ( )

502. STEERED TRAILERS.

01. Steered Trailers. Steered trailers not controlled from the truck cab shall be designed, constructed, and operated in accordance with this section. ( )

a. Secure seat. A secure seat with substantial foot rests shall be provided for the steerer at the rear of the bunk. Any arrangement that permits the steerer to ride in front of the bunk is prohibited. ( )

b. Unobstructed exit. The seat for the steerer shall be so arranged that the steerer has an unobstructed exit from both sides and the rear. ( )

c. Bunk support. The bunk support shall be so constructed that the steerer has a clear view ahead at all times. ( )

d. Adequate means of communication. Adequate means of communication shall be provided between the steerer and the truck driver. ( )

e. Eye protection and respirator. Eye protection and respirator shall be provided for the steerer. ( )

f. Fenders and splash plates. The trailer shall be equipped with fenders or splash plates to protect the steerer from mud and dust so far as possible. ( )

g. Lights. If used during a period of reduced visibility on roads not under the control of the Idaho Transportation Board, counties or cities, the trailer shall be equipped with head, tail and stop lights. ( )

503. COMMON CARRIERS.

01. Responsibility. It shall be the responsibility of the common carrier, and particularly the operator of the common carrier, upon entering the premises of any sawmill, woodworking or allied industry, to exercise all possible caution and to use all necessary safety devices and precautions to their fullest extent. ( )

02. Audible and Visual Warning Devices. ( )

a. All common carriers equipped with audible and visual warning devices shall activate such warning devices before entering a danger zone, and they shall remain activated as long as the carrier is moving in that zone. ( )

b. A danger zone shall be defined as an area where men or vehicles are working or normally work. ( )

03. Train Operations. When a train is operating on a plant railway system, the safety rules shall apply as outlined by the Association of American Railroads governing train, engine and transportation of employees. ( )

504. SELF-LOADING LOG TRUCKS.

01. Self-Loading Log Trucks. Self-loading log trucks manufactured after January 1, 1981, shall be equipped with: ( )

a. A load check valve (velocity fuse) or similar device installed on the main boom. ( )

b. A seat that is offset from the point of attachment of the boom. The seat and boom structure shall rotate concurrently. ( )

02. Operator. The operator of a self-loading log truck shall not: ( )

a. Heel the log over his head; or ( )

b. Heel the log on the operator side of the boom of the seat if offset from the point of attachment of the boom. ( )

03. Safe and Adequate Access. A safe and adequate means of access to and from the loading work station on self-loading log trucks shall be provided. ( )

04. Overhead Hazards. A self-loading log truck shall not load itself or another truck when the loading process is under or within a guyline circle or similar overhead hazard. ( )

05. Trailers Secured. Self-loading truck trailers shall be secured to the truck when the trailer is being hauled on the truck. ( )

505. -- 550. (RESERVED)

SUBCHAPTER L – LOG DUMPS, LANDING, LOG HANDLING EQUIPMENT, LOADING AND UNLOADING BOOMS, AND TRAILER LOADING HOISTS (Rules 551 - 600)

551. SPECIFIC REQUIREMENTS.

01. Log Dumps, Landings, Log Handling Equipment, Loading, and Unloading. ( )

a. Only authorized persons shall operate log handling equipment. Machine operators shall be capable and experienced personnel. No persons other than the operator may be in the operator's compartment while machinery is operating, except for purposes of operating instructions. Unnecessary talking to the operator of log handling equipment while the machine is in operation is prohibited. ( )

b. Machine operators shall make necessary inspection of machines each day before starting work. All repairs or adjustments shall be made before any strain or load is placed upon the equipment. ( )

c. Substantial barriers or bulkheads protecting the operator shall be provided for all log handling machines where the design, location, or use of such machines exposes the operator to material or loads being handled. Such barriers or bulkheads shall be of adequate area and capable of withstanding impact of materials handled. ( )

d. A safe and adequate means of access to, and egress from, the operator's station shall be provided.

Necessary ladders, steps, step plates, foot plates, running boards, walkways, grab irons, handrails, etc., shall be provided and maintained. ( )

e. All moving parts shall be guarded in an approved manner to afford complete protection to the operator and other workers. ( )

f. Throttles and all power controls shall be maintained in good operating condition. ( )

g. Landings shall be prepared and arranged to provide maximum safety for all employees and shall provide ample space for the safe movement of equipment and storage and handling of logs. ( )

h. Adequate means shall be used to prevent logs from rolling into the road or against trucks. Workers shall be sure that logs are securely landed before approaching them. While unhooking chokers, workers shall choose the safest approach. This is usually from the upper side of the log. ( )

i. Logs shall not be landed at loading areas until all workers, tractors, trucks, or equipment are in the clear. All persons shall stay in the clear of running lines, moving rigging, and loads until rigging or loads have stopped. ( )

j. The loading machine shall be set so that the operator shall have an unobstructed view of the loading area, or a signalman shall be properly placed and his signal shall be followed. Signaling the operator shall be done by standard hand signals, whistles, or other positive means of communication. ( )

k. Machines, sleds, or bases shall be of sufficient strength to safely withstand moving, and machines shall be securely anchored to their bases. ( )

l. Mufflers shall be installed on all internal combustion engines of log handling equipment and located or guarded in such a manner as to prevent accidental contact with the muffler or exhaust pipes and afford protection from fumes. ( )

m. Brakes shall be installed on all machine drums and maintained in effective working condition. ( )

n. Brake levers shall be provided with a ratchet or other equally effective means for securely holding the drum. ( )

o. Brake bands shall have a safety factor of five (5) times the stress to be imposed and they shall be of a design which will render them impervious to exposure. Operators shall test brakes before lifting any load at the start of each shift. ( )

p. In no case shall stresses in excess of the manufacturer's recommendation be permitted. Equipment not carrying a manufacturer's recommendation shall not exceed stresses of more than one half of the yield strength of the material used. Conversion of cranes, shovels, etc., into yarders shall be in conformity with these rules. Necessary guylines or outriggers shall be provided and used to effectively prevent mast, A-frames, etc., from tipping or overturning. ( )

q. The manufacturer's recommendations for line sizes, if in compliance with these rules, shall be followed and such line sizes shall not exceed the rated capacity of the machine using it. ( )

r. Fork lifts or arms, tongs, clams or grapples shall be lowered to their lowest position and all equipment brakes set before the operator leaves the machine. ( )

s. Log unloaders shall not be moved about the premises for distances greater than absolutely necessary with the lift extended or with the loads higher than necessary for clear vision. ( )

t. All log handling machines which have lift arms that create a shear point with the driver's cab or position shall be provided sheer guards that will eliminate the operator's exposure to such hazard. Grapple arms or

other positive means of keeping logs on the forks shall be required on fork lift-type loading machines. ( )

u. All workers shall be in the clear and in view of the machine operator before a lift is made. ( )

v. All mobile log handling machines shall be equipped with rearview mirrors, a horn or other audible warning device, and lights front and rear so as to illuminate the entire length of the load being lifted or carried. An automatic warning device that will activate when the vehicle is moved is preferable in areas where other workers are employed. ( )

w. Logs or loads shall not be swung over occupied equipment or workers and no person shall ride the load or rigging. ( )

x. While logs are being loaded, no person shall remain on the chain deck or behind the truck cab protector where they could be pinned between the end of a log and cab, tank, or cab protector. Cab protectors shall be cleaned of all loose gear before trucks are moved from the landing. ( )

y. An unimpaired clearance of not less than three (3) feet shall be maintained from swinging or moving parts of machines, where such swinging or moving parts create a hazard to personnel. If this clearance cannot be maintained, suitable barricades or safeguards shall be installed to isolate the hazardous area. ( )

z. A-frames, towers, masts, etc., shall be designed and constructed to provide adequate structural strength and height for positive control of materials or loads lifted. When in use, they shall be guyed or braced to provide stability and prevent tipping. Their bases shall be secured against possible displacement. ( )

aa. All log handling equipment shall be equipped with brakes capable of holding and controlling the vehicle with capacity load. ( )

bb. A limit stop which will prevent the lift arms from over-traveling shall be installed on all electric powered log unloaders. ( )

cc. Gas powered vehicles shall not be refueled while motor is running nor in the vicinity of smoking or open flames. ( )

dd. All log handling equipment shall be equipped with approved fire extinguisher of at least five (5) B.C. rating easily accessible to operator. ( )

ee. Methods of unloading logs shall be properly arranged and used in a manner to provide protection to all employees. ( )

ff. After cars or trucks are spotted at such dump or landing, no person will be permitted to pass between a brow log and a truck or rail car. ( )

gg. Where there is danger of tongs or hooks pulling out of the logs, straps shall be used. ( )

hh. All equipment should be so positioned, equipped, or protected so that no part shall be capable of coming within ten (10) feet of any power line. ( )

ii. Bunk logs shall extend not less than twelve (12) inches beyond the bunks, with the exception of non-oscillating bunks. ( )

jj. The method of loading shall be such that the logs in any tier or layer unsecured by stakes or cheese blocks shall have their centers inside of the centers of the outer logs of the next lower tier or layer so that the load is stable without the aid of binders. Logs shall be well saddled without crowding so that there will be no excessive strain on the binders, bunk chains, or stakes. No more than one half (1/2) of any log shall extend above the stakes unless properly and securely saddled. ( )

kk. Binders shall be so placed that they will not be fouled by the unloading machine and that they may be released from the side on which the unloader operates. Proper protection shall be provided for workers while removing wrappers. ( )

ll. Truck drivers shall be in the clear and in view of the log unloader operator before forks are moved into the load or against it, before a lift is made. All persons are prohibited from standing under, or near, the ends of logs being lifted or moved. ( )

mm. Loads or logs shall not be moved or shifted while binders are being applied or adjusted.
NOTE: For logs in transit see Section 501 of these rules "Log Truck Transportation." ( )

nn. All log dumps, trailer loading areas, and landings shall be kept reasonably free from bark and other debris. ( )

oo. Logs in storage decks shall be so arranged as to prevent logs from rolling off the face of the deck. ( )

pp. All log load wrappers shall be arranged so that they must be released in view of the unloader operator or signal person. When binders are released by remote control devices and when the person releasing the binders is in a safe location, and when in view of the unloading operators, or signal person, the binders may be released from either side. After the unloading machine is in position to hold the load, the binders shall be removed and the person removing them shall be in a safe location in view of the operator. The operator will be given a signal by the person releasing the binders before the machine or load is moved. ( )

02. Trailer Loading Hoist/Sawmill Log Dump. ( )

a. The hoist shall be designed and constructed in accordance with the National Electrical Code, so as to provide safe loading or unloading of the trailer. ( )

b. The hoist shall be equipped with a limiting device to maintain safe take-up limits of line on the hoisting drum. ( )

c. Regular service and inspection of the hoist and hoisting equipment shall be made to assure reliable serviceability of the facility. ( )

552. -- 600. (RESERVED)

SUBCHAPTER M – HELICOPTER LOGGING
(Rules 601 -- 650)

601. GENERAL REQUIREMENTS.
Safety requirements are as follows: ( )

01. Briefings. Prior to each day's operation, a briefing shall be conducted. This briefing shall set forth the daily plan of operation for the pilot and ground personnel. ( )

02. Personal Protective Equipment. Personal protective equipment for employees receiving the load shall, as a minimum, consist of complete eye protection and hard hats secured by chinstraps. ( )

03. Loose-Fitting Clothing. Loose-fitting clothing likely to flap in the downwash, and perhaps be snagged on the hoist line, shall not be worn. ( )

04. Reduced Visibility. When visibility is reduced by dust or other conditions, ground personnel shall keep clear of main and stabilizing rotors. ( )

05. Unauthorized Personnel. No unauthorized person shall be allowed to approach within fifty (50) feet of the helicopter when the rotor blades are turning. ( )

06. Approaching or Leaving Helicopter. All employees approaching or leaving a helicopter with blades rotating shall remain in full view of the pilot and remain in a crouched position. ( )

07 Areas to Avoid in Helicopter. Employees shall avoid the area from the cockpit or cabin rearward unless authorized to be there by the helicopter operator. ( )

08. Approach and Departure Zones. Helicopter approach and departure zones shall be designated and no equipment or personnel will occupy these areas during helicopter arrival or departure. ( )

09. External Loads. Helicopters with an external load shall not pass over areas where fallers are working. ( )

10. Open Fires. Open fires shall not be permitted in an area that could result in such fires being spread by rotor downwash. ( )

11. Compliance with FAA Regulations. Helicopter operations shall comply with any applicable regulation of the Federal Aviation Administration. ( )

12. Protective Precautions. Every practical precaution shall be taken to provide for the protection of employees from flying objects in the rotor downwash. ( )

602. SPECIFIC REQUIREMENTS.

01. Signal Systems. ( )

a. Signal systems between air crew and ground personnel shall be understood and checked before hoisting the load. This applies to either radio or hand signal systems. ( )

b. There shall be constant reliable communication between the pilot and a designated signalman during the period of loading and unloading. ( )

c. The helicopter shall be equipped with a siren to warn workers of hazardous situations. ( )

02. Loading Logs. ( )

a. It shall be the responsibility of the firm, supervisor, or person who is in charge of the actual loading operation to comply with the provisions of these rules applicable to log loading. ( )

b. The helicopter operator shall be responsible for the size, weight and manner in which loads are attached to the helicopter. If, for any reason, the helicopter operator believes the lift cannot be made safely, the lift shall not be made. ( )

c. When employees are required to perform work under hovering aircraft, a safe means of access shall be provided for employees to reach the hoist line hook and engage or disengage cargo slings. ( )

d. Employees shall not work under hovering aircraft except while hooking or unhooking loads. ( )

e. The weight of an external load shall not exceed the manufacturer's rating. ( )

f. The hook-up crew shall not work on slopes below felled and bucked timber when an unsafe situation exists. Culls left, which have a potential of rolling, should be moved to a safe position. ( )

03. Loading and Landing Areas. ( )

a. The minimum dimensions of a drop zone shall be determined by the length of the logs being

hauled. All zones shall be at least one and one-half (1 1/2) times as long, and as wide as the length of the average log being harvested. ( )

b. Landing or loading machinery shall be a reasonable distance away from where logs are to be landed. ( )

c. Landing crew shall be in the clear before logs are landed. ( )

d. The approach to the landing shall be clear and long enough to prevent tree tops from being pulled onto the landing. ( )

e. Separate areas shall be designated for landing logs and fueling helicopters. ( )

f. Sufficient ground personnel shall be provided for safe helicopter loading and unloading operations. ( )

g. A clear area shall be maintained in all helicopter loading and unloading areas. ( )

h. Emergency landing areas for injured workers shall be located within a reasonable distance from all working areas. ( )

04. Hooks and Chokers. ( )

a. The electrical activating device of all electrically operated cargo hooks shall be designed and installed to prevent inadvertent operation. In addition, these cargo hooks shall be equipped with an emergency mechanical control for releasing the load. ( )

b. Logs will be laid on the ground and the helicopter completely free of the chokers before workers approach the logs. ( )

c. One (1) end of all the logs in the turn shall be touching the ground and at an angle no greater than forty-five degrees (45°) before the chokers are released. ( )

d. If the load must be lightened, the hook shall be placed on the ground on the uphill side of the turn before the hooker approaches to release the excess logs. ( )

603. -- 650. (RESERVED)

SUBCHAPTER N – RECOMMENDED SAFETY PROGRAM
(Rules 651 - 700)

651. INTRODUCTION.

01. Scope. ( )

a. These rules are part of the accident prevention program of the state of Idaho. This program is dedicated to the safety and well-being of all workers in Idaho's logging industry. It has been established according to the processes prescribed by law. ( )

b. These rules contain the primary safety rules for the logging industry. However, other Idaho Safety Standards promulgated and adopted by the Industrial Commission shall be applicable to this industry where not inconsistent with the provisions herein, or where any particular activity which is being carried on is not specifically covered or regulated herein. ( )

02. Enforcement. The enforcement of these rules is the responsibility of the Division of Building Safety. These rules will not serve their purpose if their requirements are considered anything but a minimum for safe operation. So much variation exists in the logging industry that each operation should be judged, not by its

compliance to the letter of this Standard, but according to a higher standard -- that of absolute safety under all conditions. ( )

03. Accident Prevention. Accident prevention is often a problem of organization and education. It does not succeed solely on detailed safety codes but consists largely of the desire to institute a common sense safety program and determination to carry out the program effectively. Effective accident prevention embodies the following five (5) principles: management leadership; employee cooperation; effective organization; thorough training; and good supervision. ( )

652. FIRE AND SAFETY POLICY.

01. Elements. The basic elements or management responsibility for fire and safety policy are enumerated in this section. ( )

02. Management Leadership. The establishment of the safety policy should be made clear to all levels of supervision, purchasing, engineering, industrial and construction; and communicated to all employees that top management has approved the operation's safety program. ( )

03. Planning. The program should be based on the following: accounting record of safety cost, accident recording system, accident investigation recommendations, operation inspection recommended corrections, employee suggestions, and job analysis to determine the work hazards. The hazard appraisal can be summarized as follows: mechanical and physical hazards; environmental hazards; and work procedure and practices. ( )

04. Management Discharge of Duty. ( )

a. If management is to discharge its duty in proper directing of the fire and safety program, it must organized a definite planned program of continuous supervision and leadership by all facets of the management organization. The very fact that safety must be woven into all operations and activities should not require extra managerial time beyond the ordinary to operate a business successfully, i.e., if the entire management team will assume their safety responsibility. ( )

b. The first task of management is to determine the operational hazards. Once these are ascertained and appraised, suitable corrective action can be initiated. If the working unit is operating, the following specific activities should be carried out to find the hazards. These are: job inspection; job analysis; accident investigation (near accident, non-disabling injuries) to determine necessary remedial action to prevent reoccurrence of the accident. ( )

05. Hazard Appraisal. The partial list of terms covered by appraisals are summarized briefly as follows: mechanical and physical hazards; adequacy of mechanical guarding of machines and equipment; preventing the use of inferior manufactured and unsafe supplies, equipment, chain, cables, sheaves, tires, power saws, tractor canopy guards, approved head protection, fire extinguishers, solvents, mill saws, etc.; and physical exhaustion such as may be caused by excessive work hours by truck drivers and mill maintenance employees. ( )

06. Environmental Hazards Inherent to the Operation. ( )

a. Personal protection devices (approved head protection, ear plugs, knee pads, proper eye protection, respirators, etc.) ( )

b. Storage and use of flammable liquids and gases (gasoline, diesel, acetone, acetylene, acids, etc.) ( )

c. All employees should be familiar with proper work signals (falling, blasting, high lead signals, loading, mill signals, operation fire signal, etc.) ( )

d. Noise and fatigue hazards that are inherent to the industry (planers, cutoff saws, jack hammers, etc.). ( )

07. Work Procedures and Practices. ( )

a. Hazards directly related to work practices should be carefully observed and evaluated. ( )

b. Work practices that should be investigated include, but are not necessarily limited to: use, care and maintenance of hand and portable power tools; degree of supervision given the worker; the extent of job training provided; the safety indoctrination and training of new or transferred employees; the proper use of fire extinguishers; the use of personal protective devices (approved head protection, shoes, etc.); and the repair and maintenance of equipment with respect to machines, mechanical handling equipment, log loaders, yarding equipment, tractors, fork lifts, overhead cranes, headrigs, etc.; ( )

08. Reporting of Injuries. ( )

a. The employer shall instruct all employees to report all job injuries to the supervisor at the time injuries occur. The employer shall check specifications for new machines, processes and equipment for compliance with existing safety standards, laws and safety requirements, and shall have such equipment fully inspected before it is placed in use. ( )

b. The employer is required to report all industrial injuries to their surety (work comp carrier) within ten (10) days. ( )

c. The employer is responsible for reporting all in-patient hospitalization, amputation, or the loss of an eye for any employee to the Occupational Safety and Health Administration (OSHA) and the Division of Building Safety Logging Safety Program within twenty-four (24) hours. ( )

09. Fatalities. All work fatalities should be immediately reported to the County Sheriff or Coroner, the Division of Building Safety Logging Safety Program, and OSHA in accordance with the Code of Federal Regulations, 29 CFR 1904.39. ( )

10. Management of Personnel. ( )

a. The recruiting and placing of a new worker on the job is a major responsibility of the management organization. Every effort should be made to match the qualifications of the worker with the demands of the job. ( )

b. The furnishing of first aid services, treatment of injuries, and inspection of working conditions is the employer's responsibility. ( )

11. Assignment of Responsibilities. ( )

a. Supervisors, purchasing agents, engineering personnel, safety directors, personnel directors, and employees have responsibilities to ensure conformance with the organization's fire and safety objectives in every operation. ( )

b. Management must accept the normal obligation for preventing accidents. In many operations it is a practice to delegate the actual administration of the safety program to a person who can devote full-time to it. In smaller operations, safety administration may be a collateral duty carried on in conjunction with some other duties. The safety director should function in a staff capacity. Because the safety director operates in a consultant capacity, ultimate responsibility for accident prevention rests with the workers' supervisor, the foreman and line production organization. There is no doubt that the foreman is the key person in every safety program. Safety is not something separate and apart from production. If the job is done right, it is done safely. ( )

c. Safety is an integral and important part of production, just as is quality and quantity, or meeting production schedules. ( )

d. All these duties are foreman or project superintendent duties, and the most important part of the line production organization. This obligation cannot be delegated. As the person in charge of production, the foreman

is responsible for the safety of his people. This fact must be made clear and should be included in the statement of policy. ( )

12. Safety Director (Part-Time or Full-Time): ( )

a. Makes periodic inspections of the operations and suggests corrective measures to eliminate hazards. ( )

b. Should assist in investigation of all types of accidents to determine the cause, so as to prevent like accidents in the future. ( )

c. Aids foremen in developing safe work procedures and practices and assists foremen in training their workers. ( )

d. Keeps accident records and makes periodic reports to the proper official on the progress being made. Reports and records; report of accidents; accident investigation report; performance report (injury frequency and severity); accident cost report; safety committee reports; report on degree of corrective action taken on different recommendations. ( )

e. Conducts or initiates safety training courses including first aid and fire fighting, where appropriate, and any other course inherent to the job (truck driver courses, power saw courses, welding, grinder usage, fork lift truck operator, etc.). ( )

f. Establishes safety committee. ( )

g. Ensures that recommendations are promptly and properly implemented. ( )

h. Checks specifications for new machines, processes and equipment for compliance with existing safety standards, laws and safety requirements, and shall have such equipment fully inspected before it is placed in use. ( )

i. He shall assist the safety committee in developing agendas for their meetings. ( )

13. Foreman Responsibilities. It is widely accepted that the foreman is the key man in attaining proper work habits in any operation. It is the obligation of management to give the most careful attention to the selection, education, and training of foremen and train them in the proper way to train employees in correct and safe work methods to attain the best production in the safest way. ( )

14. First Aid Training. It shall be the responsibility of management to arrange to have all employees take a full course in first aid training. It is required that supervisory personnel shall take an approved first aid course, and have a current first aid card. ( )

15. Injury Record and Reporting System. ( )

a. If an employer had ten (10) or fewer employees at all times during the last calendar year, it does not need to keep OSHA injury and illness records unless OSHA or the Bureau of Labor Statistics (BLS) informs the employer in writing that it must keep records under OSHA regulations. However, as required by such regulations, all employers covered by the OSH Act must report to OSHA and the Division of Building Safety Logging Safety Program any workplace incident that results in a fatality or the hospitalization, the amputation of a limb, or the loss of an eye for any employee. ( )

b. For those employers subject to the injury and illness recording requirements under OSHA, the employer shall establish in its main Idaho office an injury record and reporting system which is consistent with reporting, record, and statistical requirements of the Occupational Safety and Health Administration (OSHA). ( )

c. Injury frequency rates shall be calculated annually commencing the first of January each year.

These rates shall be kept on file in the office of the employer for at least four (4) years after the date of entry thereof, and shall be made available to the Division of Building Safety, upon request. ( )

d. The injury frequency rate shall be the number of lost time injuries to all employees per one million (1,000,000) man hours of exposure. The frequency rate is computed by multiplying the number of lost time injuries by one million (1,000,000) (the standard of measurement) and dividing the product by the total number of man hours worked during the period. The formula is expressed as follows: Frequency equals the number of lost time injuries times one million (1,000,000) total man hours of exposure. ( )

e. A lost time injury shall be the term applied to any injury, arising out of, and in the course of employment which makes it impossible for the injured person to return to an established regular job at the beginning of the next regular shift following the shift during which the injury occurred, or some future shift. ( )

f. Man hours of exposure shall be the total number of man hours actually worked by all personnel in the industrial unit during the period for which the rate is being computed. ( )

16. Training and Education. ( )

a. Training and education includes: ( )

i. Establishment of effective job training methods and safety education. ( )

ii. First aid courses, proper work signals and job hazard warnings. ( )

iii. Pamphlets, bulletin boards, safety meetings, posters, etc. ( )

b. The employer shall establish an adequate job training and safety education program. The relationship of safety to job quality and modern quantity production methods should be clearly understood. Good work production is governed by careful planning and accurate control of all phases of the operation. Accidents are the result of inadequate planning of faulty operation. ( )

c. Safety must be made an essential and integral part of every operation and integrated into the activity if the most successful quantity production is to be attained. The soundness of this statement has been proven many times by comparing the accident cost with the day by day curve of production. ( )

d. It is the responsibility of management to train employees in all phases of the work they are assigned. The worker training should begin at the time of employment with a careful presentation of the general safety information the employee must have to work on and in logging and lumbering or wood working operations. When the worker is placed on the job, the worker must be given detailed training on proper work methods for accomplishment of the job. The correct way is the safe way. Telling is not training. ( )

e. People learn to do things primarily through action. The employee's job training should be given using the five (5) step job training method: ( )

i. Tell the employee; ( )

ii. Show the employee; ( )

iii. Have the employee do it; ( )

iv. Correct until the employee does it right; and ( )

v. Supervise to see that the employee keeps doing it right. ( )

f. Education and promotion are a supplemental means of reducing injuries. This device employs any number of methods to accomplish results. A good program may use but will not overemphasize emotional appeal to the workers using such devices as scholarships, stamps, posters, safety meetings, contests, and awards. It is

management's responsibility to integrate education and training program and balance its effectiveness to employee training. Unsafe acts or unsafe work practices are the result of failure to train workers in safe work procedures. In establishing or operating a safe and quality work program, an appraisal of unsafe work procedures and poor quality of work is called for, and job training methods initiated to correct these practices. ( )

17. Employer, Employee, and Labor Representative Cooperation. ( )

a. The workers have a responsibility to obey the units safety rules, smoking rules, report unsafe conditions, to serve on the different safety committees, perform their work in a safe way, and to help fellow workers by showing them how to do their job safely. ( )

b. Many safety programs fail because the worker has not been made to feel that it is their program; or that they can contribute as well as benefit from the program. It often fails because it lacks employee participation and interest. The fact that employees are given the opportunity to participate and to contribute to the program not only opens a reservoir of valuable information on practical experience in accident prevention, it also gives the employee a feeling of being a part of the organization. ( )

c. The committee on safety should be made up of personnel selected from management and workers. Management members are supervisors and worker members may be selected by the union or by the employees. ( )

d. The labor unions should help develop a safe behavior among the workers. ( )

18. Maintenance of Safe Working Conditions. ( )

a. The employer shall provide a safe and healthy work area in which to work, including purchasing of safe equipment and tools and provide proper maintenance of such equipment. ( )

b. Since a safe and healthy place to work is the very foundation of the safety program, the mechanical, physical, and environmental conditions should be given first consideration. ( )

c. For almost every accident there are typically two (2) contributing causes - an unsafe condition and an unsafe act. A safe and healthy place to work will diminish or eliminate the first cause, the unsafe condition; but unless the unsafe act is corrected, accidents will continue to occur. Unsafe acts may stem from a number of factors, such as improper selection of the worker for the job, lack of job training, physical or mental limitations or inadequate supervision. When a safety program is first established or a new project with a new crew is started, this may necessitate a thorough periodic survey of the entire operation to determine hazards. ( )

19. Remedial Measures of Corrective Action. ( )

a. The employees shall support and correct the findings of job analysis, inspections, accident investigations, employee suggestions, etc. ( )

b. The assumption of responsibility for fire and accident prevention by management carries with it the continuing responsibility to assess the progress being made on the program, and where progress is unsatisfactory to take necessary steps to bring about improvement. Inspection alone is primarily a means of finding and eliminating fire and physical hazards, particularly in connection with enforcement. All educational and promotional activities should be integrated with inspection activities, and should be based on the specific needs of the establishment or operation. Inspection and educational and promotional programs are sometimes looked upon as entirely unrelated activities rather than a single integrated program. ( )

c. None of the foregoing activities are of value unless followed by effective corrective action. The responsible executive within top management must establish specific procedures to effect proper and complete corrective action in each area for problems that occur. In well-managed organizations the areas of responsibility are clearly defined. The activities are well coordinated, supervision is adequate and proactive, employees' safety behavior is excellent, and policies are well-defined to permit smooth organization. This is not difficult; the corrective measures are applied as part of the day to day operating procedure. ( )

20. Safety Order By the Administrator. In accordance with the provisions of section 67-2601A (3), Idaho Code, the administrator may issue a safety order requiring an owner, operator or other party responsible for ensuring safe logging operations to immediately stop work or close any work site, or portion thereof where an inspection has revealed evidence of a condition that poses an immediate threat of bodily harm or loss of life to any person. The process governing the issuance of a safety order is contained herein this section. ( )

a. Upon receiving information evidencing an unsafe condition or unsafe practices at any logging workplace or place of employment, the administrator shall inspect or cause to be inspected such place of employment unless such information was obtained by previous inspection of the Division. If upon such inspection the administrator determines that an unsafe condition or unsafe practice exists which may pose an immediate threat of bodily harm or loss of life, the administrator may issue a safety order requiring the employer to immediately stop work or close any work site, or portion thereof. Any safety order issued by the administrator shall specifically identify the unsafe condition or practice, as well as the safety risks associated therewith. Written notice of such order shall immediately be provided by the administrator to the owner or operator of the business, or any other appropriate party responsible for abating the unsafe condition or practice. ( )

b. Upon receiving such notice from the administrator, such owner, operator or responsible party shall immediately comply with such, and may notify the administrator in writing of their objection to the notice and request to contest such at a hearing. The owner, operator or responsible party shall provide the administrator with information, documentation, or other evidence supporting their objection. ( )

c. Upon receipt and review of such information from the owner, operator, or responsible party, the administrator may reconsider the matter and issue appropriate findings to the owner, operator, or party responsible for abating the unsafe condition or practice, including rescission of the order. ( )

d. If after review it is the determination of the administrator to keep the safety order in place, he shall so notify the owner, operator or responsible party and designate a time and place for hearing, and may assign the matter for hearing by a hearing officer. The hearing shall be afforded at such time not to exceed five (5) business days from the date the administrator received the notice of objection unless additional time is requested by the owner, operator, or responsible party. The hearing proceedings shall be governed by the provisions of Title 67, Chapter 52, Idaho Code. The hearing officer shall issue an order in accordance with Section 67-5243, Idaho Code. The hearing may be held at such location or by such means as the administrator determines most convenient for the parties. ( )

e. The safety order shall remain in effect, and shall not be rescinded until the administrator has determined that the safety threat has been corrected or removed from the workplace. Upon verification by the administrator that the safety threat has been corrected or otherwise removed from the worksite, the administrator shall immediately notify the owner, operator or responsible party of the rescission of the safety order. Any party aggrieved by the final order of the administrator shall be entitled to judicial review thereof in accordance with the provisions of Title 67, Chapter 52, Idaho Code. ( )

f. Any person who knowingly fails or refuses to comply with the provisions of a safety order issued by the administrator shall be guilty of a misdemeanor, and the administrator may seek criminal prosecution of any such violations. ( )

653. -- 700. (RESERVED)

SUBCHAPTER O – CABLE-ASSISTED LOGGING SYSTEMS (Rules 701 - 999)

701. MACHINE SAFETY REQUIREMENTS.

01. Harvesting Machines. Harvesting machines for cable-assisted logging operations shall comply with each of the following: ( )

a. Meet the protective structure requirements set forth in IDAPA 07.08.10.010; ( )

b. Be equipped with a certified roll-over protective structure (ROPS); and ( )

c. Be equipped with at least a four (4)-point restraint system approved by the machine's manufacturer or a qualified person. ( )

02. System Approval. The cable-assisted logging system shall be designed and constructed for cable-assisted logging applications by the original equipment manufacturer, or approved for cable-assisted logging applications in writing by the original equipment manufacturer or a registered professional engineer. ( )

03. Operation of System. The cable-assisted logging system shall be operated, inspected and maintained in accordance with the manufacturer's recommendations, specifications and limitations, or if no manufacturer's recommendations exist, then by the recommendations of a registered professional engineer. Cable-assisted logging systems not in safe operating condition shall be removed from service until repaired by a qualified person. ( )

702. TETHERED LINE SAFETY REQUIREMENTS.

01. Inspection of Tethered Lines. Tether lines shall be new wire rope and have a rated breaking load according to the cable-assisted logging system manufacturer's recommendations and specifications. At a minimum, a competent person shall inspect the entire length of each tether line and drum connection prior to the startup of each cable-assisted logging operation, and thereafter on a monthly basis. A competent person shall also inspect the first fifty (50) feet of each tether line daily prior to use. These inspections shall be documented in writing. Tether lines must not be spliced and shall be replaced if there is evidence of chafing, sawing, crushing, kinking, crystallization, bird-caging, significant corrosion, heat damage, other damage that has weakened the tether line. ( )

02. Line Tension. The tether line tension and machine travel shall be synchronized or automatically held constant to ensure tether line tension is continuously provided and does not exceed thirty-three percent (33%) of the rope's rated breaking load. The operator shall have an immediate and self-reliant or automated method to identify tether line tension, winch rotation and speed, amount of line on and off the drum, and anchor movement. ( )

03. Tether Line Components. All tether line assembly components shall be rated with a greater safe working load than the wire rope. Tether line attachment points and hitches shall be engineered and certified to maintain a safety factor equal to or greater than the recommendations and specifications of the cable-assisted logging system manufacturer. Inspections of tether line assembly components (except drum connection as specified in Subsection 011.01 of these rules), hitches, winches, machines, and anchors shall be performed daily by a competent person prior to use. ( )

703. OPERATION AND SAFETY REQUIREMENTS.

01. General. Cable-assisted logging systems shall be operated, inspected and maintained in accordance with the manufacturer's recommendations and specifications. Inspections shall be documented in writing. ( )

02. Planning. All cable-assisted logging operations shall be planned by the operator and a competent person who has the knowledge, training or experience to identify existing and predictable hazards in the work site surroundings or working conditions, which could be hazardous to employees, and has been authorized by the employer or employer representative to eliminate the hazard or take corrective action therefrom. Items to consider during site-specific planning must include, but are not limited to, the following: ( )

a. Experience of the operator; ( )

b. Limitations of the equipment; ( )

c. Soil and terrain conditions; ( )

d. Environmental conditions; ( )

e. Poor visibility and lighting conditions; ( )

f. Weather conditions; ( )

g. Direction of travel; ( )

h. Requirements for turning the machine on slopes; ( )

i. Load sizes; ( )

j. Method and adequacy of anchorage; and ( )

k. Any other condition that may adversely affect operations. ( )

03. Operator Qualifications. Cable-assisted logging operators shall have documented training or adequate experience to safely operate the equipment on slopes. ( )

04. Operating Plans. A cable-assisted logging system operator shall have a written operating plan on site detailing the following: ( )

a. Tether line replacement criteria; ( )

b. Cable size, type and breaking strength, and method of assurance that tensions do not exceed one-third (1/3) of breaking strength to maintain a 3:1 safety factor or greater; ( )

c. Inspection and maintenance to be performed on tether lines, end connectors, machines and winches; ( )

d. How the operator will use tension limiting controls to maintain desired tension; ( )

e. How the winch cable tension and machine travel are synchronized; ( )

f. How the operator will monitor machine slope, anchor movement, winch tension, amount of line on and off drum, and winch function; ( )

g. How the tether line attachment points to the harvesting machine are engineered to withstand potential loads; ( )

h. All harvesting machine modifications that allow it to operate on steep slopes, including operator harness or restraint system; ( )

i. How pre-operations planning and daily assessments will identify hazards for soil and terrain conditions; ( )

j. How the operator will determine if soil and terrain conditions are unsafe during operations; ( )

k. How operators will report new hazards identified during operations; ( )

l. Operating guidance given to the operator; and ( )

m. How emergencies are handled by the system, including line failure, machine failure, winch failure, anchor failure, winch machine movement or anchor movement, and whether there is an emergency stop for the operator or at the anchor. ( )

05. Unsafe Conditions. The employer shall establish and use procedures for operators to report unsafe

conditions to a supervisor or qualified person. Such conditions must be corrected prior to resuming cable-assisted logging operations. Procedures shall also include steps to take in the event of equipment breakdown and for upset conditions. ( )

06. Warning Signs. Effective signage shall be affixed to all remotely operated equipment warning employees and others that lines and machines may start, stop, or move without warning. All employees working in close proximity of cable-assisted logging operations must receive training that enables them to recognize the potential hazards involved and to maintain safe distances. ( )

704. -- 999. (RESERVED)