Subchapter A. Submission Requirements for Filings and Departmental Actions Related to Such Filings

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28 TAC §§3.4004, 3.4005, and 3.4009

INTRODUCTION The Texas Department of Insurance (TDI) adopts the repeal of 28 TAC §§3.1 - 3.8, and new sections in Division 1, containing §3.1 and §3.2; Division 2, containing §§3.10 - 3.23; Division 3, containing §3.40 and §3.41; Division 4, containing §§3.50 - 3.52; and Division 5, containing §§3.60 - 3.62, concerning filing and submission requirements for life, annuity, accident, health, and health maintenance organization (HMO) products. TDI adopts the amendments to §3.3100 and repeal of §3.3101 and §3.3102 of Subchapter S, concerning readability. TDI also adopts the amendments to §§3.4004, 3.4005, and 3.4009 of Subchapter Z, concerning certain life, accident, health, and annuity forms that

are exempt from review, and the repeal of §3.4020, concerning policy form certifications in connection with exempt filings.

The repeals are adopted without changes to the proposal published in the October 4, 2024, issue of the *Texas Register* (49 TexReg 8018). The commissioner adopts §§3.12, 3.15, 3.19, 3.22, 3.50, 3.60, 3.62, 3.3100, and 3.4005, without changes to the proposed text in the same issue. Sections 3.1, 3.2, 3.10, 3.11, 3.13, 3.14, 3.16 - 3.18, 3.20, 3.21, 3.23, 3.40, 3.41, 3.51, 3.52, 3.61, 3.4004, and 3.4009 are adopted with changes in response to public comment and to make nonsubstantive changes to update punctuation and grammar, reflecting current agency drafting style and plain language references.

In separate rulemaking, TDI adopts amendments to 28 TAC §7.1301 and repeals §7.1302, concerning the billing system for regulatory fees, to be consistent with new and amended sections in 28 TAC Chapter 3. The adopted amendments and repeal in Chapter 7 are also published in this issue of the *Texas Register*.

REASONED JUSTIFICATION. This adoption streamlines and modernizes the filing processes for life, annuity, accident, health, and HMO products, including form, rate, network, and advertising filings. These rules last underwent significant updates in 2003. The adoption:

- updates standards governing all filings that are submitted to TDI's Life and Health Division through SERFF;

- repeals provisions related to the manual TDI billing system;

- aligns filing procedures across the Life and Health Division by extending filing rules to apply to HMO and network filings;

- limits excessive use of variability in a filing to help TDI ensure compliance and promptly process filings;

- addresses acceptable methods of premium payment and circumstances when third-party payments must be accepted;

- expands the applicability of readability and plain language requirements to all life, annuity, credit, accident, health, and HMO products, other than group annuities and major medical products subject to existing plain language rules;

- strengthens consumer protections related to applications by adding disclosure requirements and clarifying that an applicant cannot be asked to sign an application before receiving a written copy;

- narrows the scope of filings eligible to be filed exempt; and

- reorganizes the rules for clarity and readability.

Descriptions of the new, amended, and repealed sections follow, organized by subchapter and division.

Subchapter A. Submission Requirements for Filings and Departmental Actions Related to Such Filings.

Repeal of §§3.1 - 3.8.

The sections being repealed last underwent significant updates in 2003. TDI repeals these sections in order to modernize and reorganize the filing requirements in the new adopted sections.

Division 1. Applicability, Scope, and Definitions.

In response to a comment, TDI changed the title of Division 1 as proposed to remove the word "severability" because it was erroneously included; the division does not address severability.

Section 3.1. Applicability and Scope. The new section generally tracks provisions contained in former §3.1, which is repealed. It explains that the subchapter applies to all form, rate, advertising, network, group eligibility, and informational filings for products including life, annuity, accident and health, credit life, credit accident and health, and HMO products. The new section differs from former §3.1 in that the former section did not apply to HMO products. The expanded applicability in the new section reflects that these filings are processed using the same submission procedures. While the section is written broadly to capture a wide range of product and filing types, it does not require issuers to make any filing that is not already required under the rules that are repealed or other existing rules. TDI has changed paragraph (1)(B) as proposed to clarify that a form filing includes any other coverage document attached to or made part of a document described in paragraph (1)(A).

Section 3.2. Definitions. The new section defines 33 terms for use in Subchapter A. Included among these are some terms contained in former §3.2, which is repealed. The definitions for these terms are updated to align with terms used by industry through the filing process. In response to comments, TDI has changed paragraph (2) of new §3.2 as proposed to clarify that in blanket coverage there are neither individual applications, nor individual underwriting. TDI has also changed paragraph (7) as proposed to add a reference to the Insurance Code within the definition of "evidence of coverage," and TDI has changed paragraph (28) as proposed to remove a reference to a subsequent electronic system designated by the department.

Division 2. General Filing Requirements.

Section 3.10. Requested Filing Mode. The new section is similar to subsections (a)(1) - (3) and (b)(1) in former §3.5, which is repealed. The new section outlines four requested

filing modes and specifies the types of filings that are eligible to be submitted on a file-and-use or exempt basis, at the option of the insurer, rather than being filed for review or approval. A filing that is not subject to review or approval may be filed in an informational filing mode. To conform with the filing modes listed in SERFF, TDI has changed the catchline of paragraph (1) as proposed to say "and" instead of "or."

Section 3.11. Submission Requirements. The new section outlines submission requirements that apply to all filing types. It aligns closely with the submission requirements found in former §3.3 and §3.4(c) and (m), which are repealed. Subsection (a) requires issuers to submit filings electronically through the System for Electronic Rates & Forms Filing (SERFF), and subsection (b) addresses how the department would handle a system outage. In response to a comment, TDI has removed from subsection (a) as proposed a reference to a subsequent electronic system.

The new section includes language from former §3.3, but updates and simplifies it in regard to transmittal information to align with SERFF submission fields. Since some information previously collected through transmittal checklists can now be collected within SERFF fields, subsection (c) of the new section specifies the information that must be included, either in applicable SERFF fields or in a transmittal checklist. As technology evolves, TDI may modify transmittal checklists to streamline filing processes and avoid duplicative requirements. Most of the information specified in subsection (c) is substantially similar to that in former §3.3 and §3.4(c) and (m). Company information in subsection (c)(1) is broader, to reflect SERFF fields. A confidentiality designation is included in subsection (c)(4) because SERFF allows all filings to be posted for public access, unless a document within the form is designated as containing confidential information. To provide a more complete listing of the types of forms or documents that might be filed, TDI has changed subsection (c)(7)(F) as proposed to add document, evidence of

coverage, and amendment to the list. Requirements in subsection (c)(10) expand on requirements from former §3.3(b)(2)(J)(ii) to include a copy of a form approved before January 1, 2012, which is the date TDI's SERFF records begin. TDI has changed subsection (c)(10) as proposed to clarify that the informational elements listed in subparagraphs (A) - (E) are in connection with the forms that the filing will be used with.

Subsection (d) of the new section addresses submission requirements for a substantially similar, exact copy, substitution, or resubmission filing, which are similar to former requirements in §3.6(a)(3), (4), and (6). Many of the certification requirements in former §3.6 are included in new §3.16. To clarify how issuers should illustrate differences, TDI has changed subsection (d)(2) as proposed to use the word "redlined" instead of "underlined."

Subsection (e) of the new section references requirements for advertising filings contained in Chapter 21, Subchapter B.

Subsection (f) of the new section specifies that TDI may ask for any additional information necessary, which aligns with former §3.6(d).

Section 3.12. Contact Person. The new section aligns closely with language in former §3.4(b). Additions include paragraph (2), requiring an issuer to provide the contact person's email address (rather than providing it "if available," as in the repealed section), and paragraph (3)(B), requiring that an issuer clearly authorize their designee to act on behalf of the issuer with respect to the type of filing. Designees might include a consulting firm, qualified actuary, or legal counsel.

Section 3.13. Filing Fees. The new section sets all form and rate filing fee amounts at $100, subject to certain exceptions, which are consistent with the fees in former §3.4(r). The new section does not apply filing fees to any other filing types (e.g., advertising,

network, group eligibility, or informational filings). These changes simplify the fee structure formerly addressed in §3.4(r). The new section requires all form and rate filing fees to be paid through SERFF. In response to a comment, TDI has changed subsection (d) as proposed to remove a reference to a subsequent electronic system designated by the department. New §3.13 requires issuers to pay filing fees at the time a filing is accepted for review and provides that TDI may consider a filing withdrawn if the issuer does not pay the fee within five business days following acceptance for review. This ensures that the appropriate fee will be paid before a filing is approved. The new section will eliminate the need for TDI's manual billing system; thus, TDI proposed to repeal 28 TAC §7.1302, which addresses TDI's manual billing system.

Section 3.14. Purpose and Use. The new section includes provisions similar to former §3.2(9) and §3.3(b)(2)(F). These provisions are included in paragraphs (1) - (4), (6), and (7) of the new section. Instead of using the term "form," which was in former §3.2(9), the new section uses the term "filing" to reflect the subchapter's focus on filing requirements. Paragraph (3)(B) provides examples of the types of key or unique provisions in an accident and health filing that must be identified, including exclusive provider benefits and innovative excepted benefit products. Innovative excepted benefit products would include experimental or nonconventional coverage types addressed in 28 TAC §3.3081 and authorized by Insurance Code §1201.103. Paragraph (5) of the new section does not duplicate a provision from former §3.2 or §3.3. It requires a filing to explain any new program or initiative addressed by the filing. Examples of this include a value-added noninsurance benefit authorized by Insurance Code §1701.061, or a steering or tiering program addressed in Insurance Code §1458.101. This provision will streamline TDI's review by helping staff understand how the filing will be used at the beginning of the

review and reducing the need to ask additional questions. In response to comment, TDI has changed paragraph (5) as proposed to add examples of a new program or initiative.

Section 3.15. Confidential Information in Filings. The new section codifies TDI's existing process for handling confidential information in filings and aligns with the Property and Casualty Filings Made Easy rules in 28 TAC Chapter 5, Subchapter M. The new subsections address public inspection of filings through SERFF Filing Access; confidentiality and disclosure under the Texas Public Information Act; a prohibition against declaring an entire filing confidential; redaction; and the confidentiality of personally identifiable information. The definition of personally identifiable information under new §3.2 does not include the name of a group policyholder, thus this section does not require an issuer to designate a group policy face page as confidential.

Section 3.16. Certifications. The new section lists requirements for certifications that are similar to those in former §3.4(j) and §3.6(a). Subsection (a) of the new section lists general certifications required for all filings to affirm the company's responsibility to thoroughly review a filing, consistent with former §3.6(a)(1). Paragraphs (1) and (2) state the certification is on behalf of the issuer and the issuer is bound by it. In response to comment, TDI has changed paragraph (3) as proposed to provide that a certification state that the issuer--rather than the individual--is familiar with the laws applicable to the filing and believes the filing is compliant. Paragraph (4) states that the individual making the certification has reviewed the filing and that the information in the filing is true and correct. Paragraph (5) states that the form filed is not deceptive or misleading; under

previous rules this certification was required only in exempt filings. Paragraph (6) affirms that, if applicable, the filing accurately reflects the Flesch score of each form.

Subsection (b) lists additional certifications from former §3.6(a)(2) that apply only to certain filings by creating new Figure §3.16(b) to clearly display when these specific certifications should be used. The first two certifications ensure that companies do not knowingly file forms with compliance deficiencies that have been previously flagged by the department. The third certification ensures that companies review and update previously filed forms as needed to comply with new requirements before submitting a substantially similar, exact copy, or substitution filing. The fourth and fifth certifications affirm that all changes to a form are identified and that any exact copy filing meets the definition. The sixth certification affirms that a substitution filing is made only for forms that have not been issued. The seventh certification affirms that a form will be marketed only as supplemental coverage. The eighth certification affirms that products created using matrix or insert page forms will comply with applicable requirements, since TDI does not review such products in their final form. The ninth - 13th certifications affirm that exempt filings will comply with Chapter 3, Subchapter Z, similar to certifications in former §3.6(a)(9).

Subsection (c) outlines the consequences for submitting false certifications by referencing Insurance Code §841.704 and §843.464, which address criminal penalties for knowingly making false statements to TDI.

Section 3.17. Form and Rate Filing Requirements. The new section updates form and rate filing requirements for efficient review. Subsection (a) specifies that, except for general use filings, a single filing may contain rates and forms only for one product.

Subsection (b) requires general use forms to be filed individually, unless the forms are reasonably related and intended to be used with one or more of the same underlying

products. These provisions are substantially similar to the former rules that are repealed; for example, former §3.4(r)(1)(A) specified the $100 filing fee applies to "each contract or policy, including . . . its certificate, . . . application, and . . . riders filed as part of the entire policy or contract." These provisions ensure that filings are accurately classified on the basis of the type of product and help TDI staff apply the correct product standards. TDI encourages issuers to identify related filings in the general information provided with the filing so that TDI can assign related filings to the same reviewer, or otherwise coordinate TDI staff to ensure prompt and consistent reviews. Issuers can also identify subsequent filings as "substantially similar" to a previous filing, which allows TDI staff to focus on new language and perform a faster review.

Subsection (c) specifies the minimum requirements for a face page.

Subsection (d) addresses the requirements for unique form numbers, which were previously addressed in former §3.4(c)(2). Form numbers are required on each page or below each matrix provision.

Subsection (e) contains requirements for limited, partial refilings that are consistent with former §3.4(h).

Subsection (f) requires amendments and endorsements to be accompanied by a revised form that incorporates the changes made. An amendment will not be approved unless the revised form incorporating the amendment (if applicable) is also approved. This requirement supports plain language and readability and ensures that when consumers are issued coverage, they receive a clean, updated document. An amendment or endorsement form should be issued only to modify a consumer's existing coverage document and should not accompany newly issued coverage. In response to comments, TDI has changed the requirement as proposed to give issuers 180 days after receiving approval for the revised version of the form before the issuer must begin using the revised form.

Section 3.18. Variable Material. The new section includes updated requirements similar to those in former §3.4(d) and (e). These provisions promote the appropriate use of variability where it adds value and efficiency. The limits on variability are necessary to address challenging reviews and ensure compliance. TDI anticipates that the limits on variable material will significantly increase speed-to-market by reducing the time issuers spend correcting deficient filings.

Subsection (a) describes the general and proper use of variable material.

Subsection (b) requires issuers to submit a statement of variability that demonstrates compliance and provides a clear explanation of how the material will vary.

Subsection (c) describes permissible uses of variability. In response to a comment, TDI has changed subsection (c) as proposed to add new paragraph (5), explaining that it is permissible for variability to be used for options selected by a group policyholder, if those options are clearly specified and their use demonstrates compliance with applicable requirements.

Subsection (d) explains limits on variability. A form number cannot be variable because TDI's approval of a form is tied to the form number. Likewise, an issuer's name cannot be variable because TDI separately approves each issuer's use of a form. Instead, issuers can submit an exact copy filing if they experience a name change or want to use the same form that was approved for another company. Different product types must be filed in separate filings so the filing reflects the appropriate type of insurance and the correct review standards can be applied. While variability cannot be used to create different product types, issuers have other tools available that support efficient filing methods, including general use, matrix provisions, insert page filing options, and the option to identify a filing as substantially similar to another filing, which allows for a streamlined review. The ranges of variability specified must be consistent with any

applicable rate filing. TDI cannot approve a form unless it can verify that the issued form will comply with applicable requirements.

Subsection (e) addresses fill-in material for life and annuity forms, consistent with former §3.4(d)(2). In response to a comment, TDI has changed subsection (e) as proposed to clarify that it only applies to individual forms.

Subsection (f) prohibits the use of variable material in life forms for text and specifications of nonforfeiture assumptions, similar to former §3.4(e)(2), and it clarifies proper use of zero-range entries.

Subsection (g) clarifies that any change to a statement of variability is considered a change to the form itself and must be filed in conjunction with the form.

Subsection (h) specifies that TDI may request examples of issued forms without variability, if needed to aid staff's understanding of how the variability will function. The limits set on variability in this section provide insurers with clear guidance on the proper and expected use of variable material to ensure efficient reviews. These limits do not restrict general use filings that can capture similar documents used in a variety of contract forms.

Section 3.19. Matrix and Insert Page Forms. The new section sets out submission requirements that apply to a matrix or insert page form filing. The requirements are similar to requirements in former §3.4(f) and (g), but they are combined where requirements for matrix or insert pages are identical. Subsection (a)(1) addresses form number requirements, and subsection (a)(2) clarifies when a matrix provision can be used in multiple products. Subsection (a)(3) requires the issuer to explain how the forms will be used. Subsection (b) explains how an insert page may be used to replace an existing page of a previously approved or exempted form, consistent with former §3.4(g)(3).

Section 3.20. Plain Language and Readability Requirements. The new section extends plain language and readability requirements to life and annuity products (other than group annuity products) and group accident and health excepted benefit products, other than major medical plans. Major medical plans continue to be subject to plain language and readability requirements under similar provisions in 28 TAC Chapter 3, Subchapter G. To promote uniformity, the requirements in this section replace similar readability requirements for individual accident and health products under 28 TAC Chapter 3, Subchapter S, which are repealed.

Subsection (a) describes the purpose of the plain language requirements.

Subsection (b) describes the forms that the plain language requirements apply to.

Subsection (c) requires applicable forms to be written in plain language.

Subsection (d) sets the Flesch Reading Ease score at 40; references the method of calculation in 28 TAC §3.602(b)(1), (c), and (d); requires a statement of the Flesch score; and states that TDI may require additional information to verify compliance. The calculation method allows certain text to be excluded, including language required by any state or federal law.

Subsection (e) provides guidance to issuers by describing plain language best practices. In response to a comment, TDI has changed subsection (e)(7)(D) as proposed to replace the word "unnecessarily" with "unreasonably."

Subsection (f) addresses how a definitions section may be used.

Subsection (g) addresses font size and formatting.

Subsection (h) specifies when a table of contents or index is required.

These provisions are in line with industry standards and provide additional guidance to aid companies in submitting compliant form filings. Most issuers are already using plain language best practices.

Section 3.21. Group Filings. The new section includes updated requirements similar to those in former §3.4(o) and §3.6(c). Group filing requirements are streamlined by not including the requirement from former §3.6(c)(2) for issuers to submit separate form filings for each group type.

Subsection (a) uses updated language to identify the Insurance Code provisions that address eligible policyholders for group and blanket coverage, applies the criteria for accident and health policyholders to apply to groups purchasing HMO coverage, specifies when an issuer must submit a group eligibility filing, and explains how group eligibility information and forms may be submitted. TDI has changed subsection (a)(1) as proposed to use "including," instead of "as follows," to ensure the rule does not constrain issuers from citing additional group eligibility statutes. Under the new section, issuers will not be required to submit the group eligibility information for review for each product being issued. Instead, if TDI has verified the group's eligibility in the past five years, the issuer will submit only an informational filing. For consistency with subsection (a)(2)(B), TDI has changed subsection (a)(2)(C) as proposed to clarify that the associated form numbers are those that are "to be issued to the group."

Subsection (b) specifies the group eligibility filing requirements for coverage to be issued to an association, which are similar to requirements in former §3.6(c)(3)(B) - (D). Those filings must identify the types of coverage the issuer will offer the association; demonstrate that the association is an eligible group policyholder; and include an alternate face page and a copy of the association's constitution, bylaws, and articles of incorporation. In recognition that subsection (b) applies to various types of organizations with different governance structures, TDI has changed subsection (b)(1) as proposed to refer to "other formative or organizational documents regulating the conduct of the association's internal affairs."

Subsection (c) specifies the group eligibility filing requirements for coverage to be issued to a trust, which are similar to requirements in former §3.6(c)(3)(D) and (F). Trust filings must include a copy of the trust agreement and an alternate face page form for each related industry group. Association trust filings also must include a list of all participating associations and a reference to the group eligibility filing for each association.

Subsection (d) requires issuers to notify TDI of additional associations within a multiple association trust by making an informational filing and is similar to requirements in former §3.6(c)(3)(E). Issuers must notify TDI of any additions to the trust upon enrollment and include additional documentation.

Subsection (e) requires issuers to submit a group eligibility filing for any type of group or blanket policyholder that is not identified in statute as an eligible policyholder, including actuarial information similar to requirements in former §3.4(q)(6). These filings are needed to determine whether it is in consumers' best interest to allow a particular "discretionary group" to offer insurance coverage.

Subsection (f) specifies information that issuers must provide when issuing a major medical health benefit plan to an association, which is similar to requirements in former §3.6(c)(3)(A) and relevant for determining the applicable requirements. For example, different requirements apply to member-only bona fide associations, bona fide employer associations, and associations issuing coverage to small employers versus large employers.

Subsection (g) clarifies that products issued to educational institutions on a group basis must be filed under Insurance Code §1131.064 or §1251.056, and that products issued to educational institutions on a blanket basis must be filed under Insurance Code §1251.353. While educational institutions are specifically identified as eligible blanket

policyholders under Insurance Code §1251.353, the statute does not specifically identify them as eligible group policyholders.

Subsection (h) is consistent with former §3.4(o), which required issuers to ensure that insurance certificates or HMO evidences of coverage being delivered to Texas residents comply with all the applicable laws of this state and include copies of out-of-state documentation.

Section 3.22. Braille and Non-English Filings. The new section provides guidance regarding braille and non-English filings. Subsection (a) aligns with former §3.4004(h) and requires a certification that the form meets the definition of an exact copy. Subsection (b) allows a filing that includes only a braille or non-English language version of a previously approved form to be filed in an informational mode or an exempt mode.

Section 3.23. Acceptance, Rejection, and Disposition of Filings. The new section includes reorganized versions of provisions in former §3.7 to clarify procedures for accepting and processing filings and to avoid restating statutory provisions. New subsection (a) addresses acceptance of filings and includes provisions similar to former §3.7(a) and (b). Subsection (a)(1) explains that filings that are subject to approval and not rejected will be considered filed as of the submission date. It also references the statutory provisions that address deemer periods. Subsection (a)(2) explains that an exempt filing that is not rejected will be considered exempt as of the disposition date. Subsection (a)(3) explains that an informational filing that is not rejected will be considered filed as of the submission date and will be closed with an informational disposition.

Subsection (b) addresses rejection of filings that are incomplete or otherwise do not meet submission requirements, similar to former §3.7(a)(2). TDI may reject a filing if an issuer does not make corrections within two business days of TDI's request for corrections. This limited timeframe reflects the straightforward nature of submission

deficiencies, in contrast to the more complex and substantive nature of the compliance standards for which corrections may be requested under subsection (c). TDI will not reopen a filing that has been rejected.

Subsection (c) is similar to former §3.7(c) in addressing requests for correction and extensions and waivers of deemer dates. These provisions are necessary to ensure that a form is not deemed approved when compliance issues have been identified. Submission requirements for corrections consist of a summary and certification of identified changes similar to those in former §3.6(a)(5)(E) and (F). TDI has changed the proposed text of subsection (c)(1)(B) to use a higher-level cross-reference to HMO rules, to avoid a conflict if those rules are reorganized. In the interest of processing filings promptly, subsection (c)(3) requires issuers to submit corrections within 10 business days. This replaces the 30-day period provided in former §3.7(c)(4) and is necessary to allow TDI to review filings within the statutory deemer dates. In response to comments, TDI has changed subsection (c)(3) as proposed to clarify that upon request from an issuer, TDI may agree to extend the time the issuer has to submit corrections.

Subsection (d) addresses how TDI will notify issuers of a filing disposition.

Subsection (e) explains that TDI may withdraw approval only after notice and opportunity for hearing, consistent with former §3.7(e).

Subsection (f) addresses issuer responsibilities to retain records related to form filings.

Division 3. Requirements Relating to Application Form Filings.

Section 3.40. Applications Generally. The new section explains TDI's expectations for application form filings. Subsection (a) requires application form filings to address the

type of contracts and products the application will be used with and whether the application will be used in paper, electronic, or telephonic form.

Subsection (b) requires issuers to submit entire applications for review and to make clear what an applicant is required to complete. This section does not require issuers to file screenshots or websites for review, but rather to include in the form filing all text that may be used in an application, however it is delivered.

Subsection (c) explains the requirements for applications to be used by multiple issuers. Subsections (a), (b), and (c) are consistent with TDI's current review standards.

Subsection (d) specifies fairness standards for questions asked on an application form. Questions must be consistent with underwriting standards, limited to information necessary to issue or administer the policy, and may not require the applicant to self-diagnose.

Subsection (e) specifies disclosure requirements for application forms, explaining that the application will become part of the contract and helping applicants understand underwriting standards. In response to comments, TDI has changed subsection (e)(1) as proposed to add "if applicable" and to clarify that the application will become part of the contract. This change clarifies that the new language will be required only for an application form that will become part of the contract. It also requires applications to include a method for applicants to opt out of electronic communications if the issuer does not seek affirmative consent. This provision helps issuers ensure that their forms and procedures comply with Insurance Code Chapter 35, as amended by House Bill 1040, 88th Legislature, 2023. Finally, it requires issuers to disclose how applicants' personal information may be obtained from third parties.

Section 3.41. Standards for Electronic and Telephonic Applications. The new section adds provisions to aid issuers in complying with appropriate delivery of applications,

consistent with TDI's current review standards. Subsection (a) references an issuer's obligation to comply with Insurance Code Chapter 35.

Subsection (b) requires issuers to provide applicants with a written copy of the completed application before signing. This provision is needed to ensure that a consumer is not asked to verbally sign an application without being able to verify that it was completed accurately. It does not prevent an issuer from delivering a written copy of the application electronically.

Subsection (c) requires issuers to deliver the completed application in a manner that allows the consumer to keep it for their records in compliance with Business and Commerce Code §322.008(a) and Insurance Code §35.004(c).

In response to a comment, TDI has changed §3.41 to remove proposed subsection (d), which would have required issuers to include a description of security procedures that will be used to verify the authenticity of an electronic transaction.

Division 4. Requirements Specific to Accident, Health, and HMO Filings.

Section 3.50. Filing Requirements for Health Plan Disclosures. The new section is similar to the requirements in former §3.4(i) and identifies each product for which an outline of coverage or similar plan disclosure is required to be filed. Applicable product filings must either include the required disclosure document or reference the filing ID that the document was filed separately under.

Section 3.51. Payment of Premiums or Cost Sharing. The new section implements Insurance Code Chapter 541 and addresses consumer protections related to restrictions on the form or manner of premium or cost-sharing payments for major medical and Medicare Supplement coverage. In response to comments, TDI has changed subsections (a) and (b) as proposed. As adopted, subsection (a) specifies that any restriction on the

form or manner of payment of premiums or cost sharing must be specified in the contract, and subsection (b) requires issuers to provide consumers with reasonable options for paying premiums and cost-sharing and prohibits issuers from requiring payment by personal check.

Subsection (c) clarifies that the section does not modify the requirements or applicability of Insurance Code §1369.0542.

Section 3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage. The new section adds clarity to the filing requirements for issuers terminating or nonrenewing all guaranteed renewable major medical coverage in a given market or service area. This is needed to provide clarity on how to file required notices. These filings give TDI the opportunity to help issuers comply. They also allow TDI to help consumers affected by terminations.

Subsection (a) references the rules that require issuers to provide notice regarding termination of guaranteed renewable major medical coverage. In response to comments, TDI has changed subsection (a) as proposed to clarify that issuers must submit an informational filing to TDI through SERFF for each applicable line of business and removed the reference to the 180-day timeframe, since that is already addressed in other rules.

Subsection (b) identifies the information that issuers must include in filings related to termination of guaranteed renewable major medical coverage. In response to comments, TDI has changed subsection (b) as proposed to clarify that it only applies to a filing made under subsection (a) when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area.

Subsection (c) clarifies that the filing requirements are in addition to withdrawal plan rules in 28 TAC Chapter 7, Subchapter R, if the termination of coverage constitutes a withdrawal under Insurance Code Chapter 827.

Division 5. Actuarial Filing Requirements.

Section 3.60. General Actuarial Filing Requirements. The new section requires issuers to submit either rate filings or other actuarial information as required by law and specifies the existing applicable statutes and rules. This section replaces provisions in former §3.1(8) and (10) and §3.4(p), which are repealed.

Section 3.61. Actuarial Information for Certain Accident and Health Filings. The new section specifies the actuarial information that must be included for certain accident and health products. This section includes updated versions of filing requirements contained in former §3.4(q)(5) and (6). Subsection (a) specifies that the section applies to individual accident and health products and group accident and health products issued to alternative types of group policyholders.

Subsection (b) clarifies that the section does not apply to rate filings for non-grandfathered individual major medical, small group major medical, Medicare supplement, or long-term care products. Rate filing standards for these are addressed in separate rules.

Subsection (c) clarifies that a premium rate schedule must be filed before being used.

Subsection (d) requires a premium rate schedule to be accompanied by an actuarial memorandum signed by a qualified actuary.

Subsection (e) specifies actuarial filing submission requirements for new products, which were not specified in the repealed sections, beyond a brief reference in former §3.4(q)(6). This information is necessary to implement Insurance Code §1251.056 and §1701.057, which require TDI to assess whether benefits are reasonable in relation to the premiums charged. In response to a comment, TDI has changed the text of §3.61(e)(2) as

proposed to clarify that issuers may file either new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer.

Subsection (f) specifies requirements for rate adjustment filings for existing products, and replaces provisions addressed in former §3.4(q)(5).

Section 3.62. Actuarial Information for Life and Annuity Filings. The new section replaces former §3.4(q)(1) and (2) to update the actuarial information required for life and annuity filings, consistent with current agency standards. Subsection (a)(1) references requirements in Insurance Code Chapter 1105. Subsection (a)(2) addresses actuarial information required for universal life filings. Subsection (a)(3) references the actuarial information required for variable life forms. Subsection (a)(4) requires a certification similar to former §3.4(q)(1)(C).

Subsection (b) addresses actuarial information required for annuity filings, which is substantially similar to former §3.4(q)(2).

Subsection (c) addresses multiple guaranteed interest charge periods.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies.

Section 3.3100. Policy Readability Generally. Amendments to the section revise duplicative readability references in Chapter 3, Subchapter S, to align with standards listed in new §3.20. Subsection (a) is amended to add the title for Insurance Code Chapter 1201, Subchapter E, and strike unnecessary references to Chapter 1201. Subsection (b) is amended to reference plain language and readability standards in new Chapter 3, Subchapter A.

Repeal of §3.3101 and §3.3102. The sections are repealed to avoid duplication of provisions related to plain language and readability standards in new §3.20.

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

Section 3.4004. Exempt Forms. Amendments to the section update the types of forms that are eligible to be filed in an exempt filing mode and the types of forms that must be filed for review. Exempt filings are not permitted for products with a history of compliance issues or consumer protection concerns.

Amendments in subsection (a) broadly exempt group and individual term life insurance forms. Exempt privileges are removed for product types that are subject to actuarial review, including whole life, endowment life, and certain limited refilings. This change will have minimal impact on issuers because the volume of exempt filings is low; an estimated four whole life filings may be impacted per year based on filing patterns in 2022 and 2023. Issuers can elect "file and use" if they do not want to wait for TDI to complete its review. The subsection is simplified to remove reference to different types of groups, forms, and products previously addressed in paragraphs (1) - (3). Individual variable life with a separate account only, which was previously specified as exempt in paragraph (3)(Q) is renumbered as paragraph (2). Subsequent paragraphs are renumbered. Nonsubstantive amendments are made to paragraphs (3) and (4) as renumbered to clarify abbreviated terms. Paragraph (5) as renumbered is amended to remove exempt privileges for limited refilings that change the mortality table or interest rates for new issues under the policy form because these filings require actuarial review.

Amendments to subsection (b) clarify that it addresses the types of life insurance forms that are not permitted to be filed as exempt. Paragraph (1) is amended to clarify that universal life includes flexible premium adjustable life. Paragraph (2) is amended to

remove universal-related life, which duplicates the reference to universal life in paragraph (1), and add whole life, consistent with the removal of ordinary life from subsection (a)(3)(A) because it is subject to actuarial review. Paragraph (3) is amended to remove adjustable life, which is now referenced in paragraph (1) and add endowment life, consistent with its removal from subsection (a)(3)(M) - (O), because it is subject to actuarial review. Nonsubstantive amendments are made to paragraphs (8) and (10) - (12) to conform to agency style, add titles to statutory citations, and replace "equity indexed" with the more commonly used term "index-linked crediting." TDI has changed paragraph (12) as proposed by substituting the word "forms" for a list of form types, consistent with other amendments to the section. New paragraph (13) is added for limited refilings for life insurance that change the mortality table or interest rates for new issues under the policy form, consistent with the amendment made in subsection (a)(4).

Nonsubstantive amendments are made in subsection (c) to conform to agency style by replacing "which" with "that," and removing the words, "including applications," because applications are already captured by the term "forms."

Amendments to subsection (d) clarify that it addresses the types of annuity forms that are not permitted to be filed as exempt. The term "index-linked crediting" replaces "equity indexed" to be consistent with the terminology more commonly used by issuers. New paragraph (6) is added to list contingent deferred annuities. TDI has changed subsection (d)(5) as proposed to conform to similar amendments to the section by substituting the word "forms" for a list of various form types that had been included in the subsection as proposed.

Amendments in subsection (e) update the types of accident and health forms that can be filed as exempt. Nonsubstantive amendments in paragraph (1)(A) and (C) simplify the exemption of certain group accident and health forms by removing reference to different types of forms. Paragraph (1) is amended to remove exempt privileges for

blanket forms in subparagraph (B) because of a pattern of compliance issues. Subsequent subparagraphs are redesignated. Nonsubstantive amendments are made to paragraph (1)(B) as redesignated to clarify the exemption for employer plans that supplement Medicare. Nonsubstantive amendments in paragraph (2) simplify the exemption of certain types of group and individual accident and health forms by removing reference to different types of forms. Paragraph (2)(C) is amended to remove exempt privileges for dental forms because of a pattern of compliance issues and clarify that hospital indemnity forms are eligible to be filed exempt. Paragraph (2)(D) is amended to remove exempt privileges for in-patient confinement and basic hospital expense coverages because, unless they are structured as hospital indemnity coverage, they are reviewed as major medical products. Subsequent subparagraphs are redesignated. A nonsubstantive amendment in paragraph (2)(H) removes the reference to Champus supplements because those policies are rarely filed, so the example is not useful. Paragraph (2)(K) is amended to remove exempt privileges for prescription drug policies because major medical review standards apply. Paragraph (3) is amended to remove exempt filing privileges for certain alternate face pages because group eligibility filing requirements are addressed in Chapter 3, Subchapter A. Under new §3.13, group eligibility filings are not charged a filing fee.

Amendments to subsection (f) remove repetitive language and clarify that it addresses the types of forms and rates that are not permitted to be filed as exempt. Paragraph (1) is amended to modernize the language related to comprehensive or major medical policies by adding a reference to "guaranteed renewable or short-term limited duration" and removing the reference to limited benefit policies, which are no longer permitted under federal law. Nonsubstantive amendments are made to paragraphs (2) - (6), including adding titles to statutory citations, replacing a reference to preferred provider rules with a reference to statute, and removing unnecessary phrases like "but not

limited to" and "the authority of." New paragraph (7) is added to list fixed indemnity coverage for more than hospital confinement because such forms often provide innovative benefits and contain compliance issues. In response to a comment, TDI has changed paragraph (7) as proposed to simplify the wording. New paragraph (8) is added to clarify that the exempt status for forms does not extend to rates that are required to be filed. TDI has identified that rates related to individual health products that have been filed as exempt are often unreasonable in relation to the benefits provided. New paragraph (9) is added to list dental policies because TDI has consistently found compliance issues related to unique requirements in Texas law.

Amendments to subsection (g) remove unnecessary language related to certifications and remove a reference to §3.4020, which is repealed. While exact copies can almost always be filed exempt, an exception is added to disallow an exact copy filing to be filed exempt for preferred provider benefit plans, so that staff can verify that these plans have satisfied examination requirements added to Insurance Code §1301.056.

An amendment to subsection (h) removes the reference to the outdated certification form. Certifications are addressed in new §3.16. For clarity and consistency with new §3.22, the term "foreign language" is replaced with references to the terms "braille" and "non-English."

Section 3.4005. General Information. Amendments to subsection (c) remove unnecessary language related to certifications and a reference to former §3.4020, which is repealed. Language is added to reference the certifications required for exempt filings in §3.16. Also, a nonsubstantive amendment is made to subsection (b) to improve readability.

Section 3.4009. Sanctions and Cancellation of Exempt Filing Privileges. The amendments to subsection (a) explain that an insurer's exempt filing privileges may be cancelled if the insurer makes an exempt filing that fails to comply, which results in TDI determining that the filing has failed audit. If TDI cancels exempt filing privileges, this will be communicated in the failed audit notice. As proposed, subsection (a) incorrectly specified that notice of failed audit will be issued consistent with §3.23; this section does not address failed audit notices. TDI has changed subsection (a) as proposed to reference §3.4008 instead of §3.23. Amendments to the section remove the requirement that TDI hold a hearing before canceling an insurer's exempt filing privilege. However, the amendments do not remove an insurer's right to request a hearing to challenge the failed audit determination, which is consistent with Insurance Code Chapter 36. In response to a comment, TDI has changed §3.4009(a) as proposed to add a sentence stating that an issuer can request a hearing if it disagrees with TDI's determination. TDI anticipates that the need to take action under this section will be rare. However, to protect consumers and maintain a fair and competitive market, it is important to ensure TDI can take prompt action when needed. Nonsubstantive amendments are made in subsections (b) and (c) to improve readability.

Section 3.4020 Section 3.4020, which contains a figure with outdated certifications, is repealed. Certifications are now contained in new §3.16. Conforming changes are made in §3.4004 and §3.4005 to remove references to former §3.4020.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on November 4, 2024. In

advance of the proposal, TDI also solicited comments on an informal draft of the rule text posted to the TDI website January 19, 2024.

Commenters: TDI received comments from three commenters. Two commenters spoke at a public hearing on the proposal held on November 7, 2024. Commenters in support of the proposal with changes were the American Council of Life Insurers, Texas Association of Health Plans, and Texas Association of Life and Health Insurers.

General Comments

Comment. One commenter states that the new rules will apply only prospectively and that previously filed documents should be audited based on rules in effect at the time of filing. The commenter recommends clarifying the applicability in the adoption order and adding rule text that specifies that forms received before the effective date will be governed by the laws and rules in effect on the submission date. The commenter also recommends clarifying that the proposed plain language and readability standards under §3.20 apply only to forms filed after the rule's effective date and do not require issuers to refile previously approved forms.

Agency Response. TDI declines to make a change. TDI agrees that the new rules will apply only prospectively but disagrees that additional rule text is needed. Staff conducting audits will be aware of the rule's effective date.

Comment. One commenter expresses appreciation for the opportunity to comment on the rule and looks forward to future collaborations.

Agency Response. TDI values the comments received and appreciates the contributions from stakeholders.

Comment. One commenter recommends reposting these rules for all stakeholders to review new language.

Agency Response. TDI declines to repropose the rules. Changes to the rules from proposal are in response to comments or to address nonsubstantive issues. No new subject matter is addressed and no new persons are affected, so reproposal is not necessary and would delay implementation of the rules.

Comments on §3.1. Applicability and Scope.

Comment. One commenter asks for clarification on whether Division 1 contains a severability provision, because the word "severability" is listed in the proposed Division title.

Agency Response. The reference to "severability" in the title of Division 1 was in error. Because case law dictates that severability is implied, TDI no longer includes severability provisions in rules. The title of Division 1 as proposed is changed in this adoption to remove this word.

Comment. One commenter notes that §3.1 does not reference the applicability of the rules to filings made under the Interstate Insurance Compact under Insurance Code Chapter 5001. The commenter also asks for clarification on how the standards in §3.41 would interact with the Compact. The commenter recommends modifying §3.1 to state that the rule does not change the uniform standards adopted by the Compact.

Agency Response. TDI agrees that filings made through the Compact are authorized under Insurance Code Chapter 5001 but believes it is unnecessary to make the requested change. Texas has joined with other states in the Interstate Insurance Product Regulation Compact. *See* Tex. Ins. Code Ch. 5001. The Interstate Insurance Product Regulation Commission states that "companies have the choice of filing products through the

Insurance Compact or filing products directly with a state. If a company chooses the latter course, then the regulator will apply the existing product standard laws and procedures of the state. If a company files with the Insurance Compact, then the Insurance Compact's Uniform Standards and review process will apply. Many companies find it more efficient and expeditious to make one filing through the Insurance Compact for all Compacting States than to make individual filings in each state."

Comments on §3.2. Definitions.

Comment. One commenter states that the definition of "blanket policy or contract" in §3.2 is inconsistent with the provisions in Subchapters H and I in Insurance Code Chapter 1251 that address blanket accident and health insurance. The commenter asks why the proposed definition specifies that a blanket policy will not have individual application or underwriting.

Agency Response. The proposed definition aligns closely with Insurance Code §1251.401, which states, "An individual application from an insured under a blanket accident and health insurance policy is not required." This definition is needed because the requirements for group and blanket coverage are different, and TDI cannot accurately review filings that are improperly classified. The definition adopts the common understanding of the term. For example, the Utah Insurance Code defines it as "covering a defined class of persons . . . without individual underwriting or application {and} that is determined by definition without designating each person covered." TDI modifies the wording of the definition to clarify neither individual applications nor individual underwriting are included in blanket coverage.

Comment. Two commenters request changes to the definition of "insert page" in §3.2 and offer alternative language describing an insert page as providing a "comprehensive

description" of a topic. One commenter states that the language being repealed in §3.4(g) is clearer. The commenter states that the proposed definition better describes a "replacement page," and that many insurers refer to insert pages as only forms that may be included or excluded from a contract based on a particular plan.

Agency Response. TDI declines to modify the definition of insert page in §3.2. It aligns closely with the requirements that were in former in §3.4(g) and is defined broadly enough to encompass both a "replacement page" and an "insert page" as described by the commenters. The proposed definition allows insert pages to be used as a modular approach to constructing contract forms, which also allows those individual forms to be replaced when necessary.

Comment. One commenter suggests modifying the definition of "rider" to read "A form that adds, expands or changes benefits or provisions."

Agency Response. TDI disagrees with the suggestion because contract changes should be filed as an amendment or endorsement. Riders are typically used to provide optional coverage, often for additional cost. They should not conflict with or modify the terms of a contract or reduce benefits.

Comment on §3.11. Submission Requirements.

Comment. One commenter expresses concern with language in §3.11 and other sections that requires issuers to use SERFF "or a subsequent electronic system." The commenter states that changes to the designated system should only be done by rule to comply with Government Code Chapter 2001. The commenter also states that SERFF is an NAIC system and suggests adding a reference to the specific SERFF Filing Manual in effect and drafting the rule to comply with Insurance Code §36.004(c).

Agency Response. TDI understands the commenter's concern about a subsequent electronic system and has changed §§3.2(28), 3.11(a), and 3.13(d) as proposed to remove that language. TDI disagrees that SERFF is a "rule, regulation, directive, or standard adopted by" the NAIC and subject to Insurance Code §36.004. SERFF is an electronic system. Since TDI is not adopting the SERFF Filing Manual, the version number is not relevant to the rule.

Comment on §3.13. Filing Fees.

Comment. One commenter asks for clarification on the structure of fees for matrix filings under §3.13(a)(3) if a filing has more than 10 matrix provisions. The commenter also asks if the matrix fee structure also applies to insert forms.

Agency Response. The fee structure under §3.13(a)(3) for matrix filings charges $50 per form (matrix provision) up to $500. Any filing with more than 10 matrix forms will be charged only the $500 maximum fee. The fee structure for matrix filings does not apply to insert pages.

Comment on §3.14. Purpose and Use.

Comment. One commenter asks for clarification on the meaning of "a new program or initiative" under §3.14(5) and whether it includes value-added services.

Agency Response. To provide additional clarification as requested by the commenter, TDI has changed §3.14(5) as proposed to include examples of a new program or initiative, including a value-added noninsurance benefit, or a steering or tiering program.

Comments on §3.15. Confidential Information on Filings.

Comment. One commenter recommends amending §3.15 to require TDI to notify an insurer before releasing information in response to an open records request, to allow the

insurer to explain why the information is or should remain confidential. The commenter suggests that this could reduce the need to request a decision from the Office of the Attorney General.

Agency Response. TDI declines to make a change because the procedure for open records is outside the scope of the rule. The language in this subsection provides clarity on how documents with confidential information should be marked in accordance with SERFF functionality. Documents that are not marked as confidential become open to the public upon filing through the SERFF public access system. Documents marked as confidential and responsive to an open records request will be referred to the Office of the Attorney General in accordance with the Public Information Act.

Comment. One commenter supports the language in subsection §3.15(f) because it clarifies how individual names can be protected in group filings.

Agency Response. TDI appreciates the support.

Comment on §3.16. Certifications.

Comment. One commenter expresses concern with the requirement under §3.16(a)(3) for individuals to certify that they are familiar with all applicable statutes and regulations, in contrast to former §3.6(a)(1)(A)(iii), which applied this certification to the company. The commenter notes that because forms are often compiled by multiple operational areas of the issuer and each area contributes specialized knowledge, it may be difficult to find one individual who is able to certify to this across the entire filing, particularly given the risk of criminal liability specified under §3.16(c). The commenter suggests modifying the certification to be at the issuer level, and striking subsection (c). A second commenter recommends TDI provide a draft certification for issuers to follow.

Agency Response. TDI understands the commenter's concerns and in response to the comment has changed §3.16(a)(3) as proposed to reference the issuer rather than the individual. TDI declines to delete subsection (c), because it is important that issuers understand the potential consequences for making false certifications. With respect to the second commenter, TDI agrees and will continue to make the text of certifications available within the transmittal checklists posted on the TDI website.

Comments on §3.17. Form and Rate Filing Requirements.

Comment. Two commenters recommend modifying §3.17(a) to specifically state that term life and accidental death and dismemberment (AD&D) benefits may be contained in an integrated document. The commenters also recommend that multiproduct group policies and applications be permitted, noting that the group policy might simply address the roles and responsibilities of the group policyholder and insurer, while the certificate addresses the coverage provisions. One commenter recommends modifying the definition of "product" in §3.2(24) to include a sentence that states, "Forms which provide both term life and AD&D in an integrated fashion will be considered as one product."

Agency Response. TDI agrees that issuers are permitted to include term life and AD&D benefits in an integrated contract but disagrees that a change to the rule text is needed. Section 3.17(a) already specifies that the rule "does not prevent an issuer from filing a product that contains multiple types of benefits that will be issued in combination in a single contract if that combination otherwise complies with applicable requirements." Section 3.17(b) permits a form (such as a multiproduct application or policy shell) to be filed on a general use basis. The definition of "product" in §3.2(24) also does not limit an issuer's ability to offer multiproduct group policies or applications. TDI recognizes that issuers sometimes combine multiple benefits in a single policy, and other times file stand-

alone riders or certificates that can be used in combination. This rule continues to permit both approaches.

Comment. Three commenters suggest changes to §3.17(f) as proposed. One commenter states that it would be administratively burdensome to immediately incorporate newly approved amendments into all forms, particularly since forms are issued to members throughout the calendar year. The commenter suggests that the rule designate a set amount of time, such as six months after approval, before issuers must begin issuing the new forms with the amendments incorporated, so that issuers have sufficient time to load and test the new forms before they are issued to members. Two other commenters suggest that issuers should be permitted to inform TDI that the text will be incorporated with the revised text for new issues and bear the original form number with an additional statement indicating the forms are amended with the form number of the endorsement or amendment. One of the commenters notes that for "issue system efficiency, insurers need the ability to issue the new benefit within a rider, even to an existing certificate." The commenter also asks for clarification on the meaning of "amendment" in this section, and states that if it refers to a legal amendment to the contract, it would be cumbersome for issuers to use a new form number when a previously approved form will be used with an amendment.

Agency Response. The term "amendment" is defined in §3.2(1), and that meaning applies to its use in §3.17(f). The requirements in §3.17(f) apply only to amendments and do not apply to riders. TDI appreciates the commenters' concerns and in response to the comments has changed §3.17(f) as proposed in the way recommended by the first commenter to provide up to 180 days for the issuer to begin issuing the revised version of the form. TDI believes this approach will mitigate the concerns from the other commenters. TDI declines to permit issuers to incorporate amendments without filing a

revised version of the form, because this would conflict with the statutory requirements for issuers to file forms with TDI. However, this does not prevent issuers from using form numbering conventions that include a version number or date to reflect the relationship between newer and older versions of a form.

Comments on §3.18. Variable Material.

Comment. Two commenters recommend changing §3.18(d)(2) to allow company names to be bracketed as variable. One commenter states that the prohibition on bracketing the company names diminishes the benefit of the Uniform Certificate of Authority Application (UCAA) process that issuers follow when undergoing a name change. If the company name cannot be variable, then the company must refile all forms after completing the UCAA name change process. A second commenter offers alternatives to subsection (d)(2) as proposed, such as allowing variability contingent on approval of a name change in a certificate of authority, a name-change endorsement, or an informational filing. The commenter also suggests clarifying that the variability of the company name permits the issuing company to change its name but does not permit a distinctly different company to use the form.

Agency Response. TDI declines to modify §3.18(d)(2) because the entity that is accepting the risk for a form is a fundamental element of a form. Under §3.4004(g), an issuer may submit filings that are identical, other than the issuer's name, as an exact copy filing that is eligible to be filed on an exempt basis. This reduces the administrative time and expense of making filings following a name change.

Comment. One commenter asks for clarification on whether the requirement in §3.18(d)(4) applies in the context of AD&D coverage issued in combination with life

insurance, where the AD&D amount is a function of the life insurance amount. The commenter assumes it does not apply in this context.

Agency Response. The limitation on using a range of variability that exceeds the range supported in the issuer's filed rates would apply only to variability within a form for which a rate filing is required. With respect to AD&D policies, a rate filing is required only for AD&D coverage issued to individuals. This provision does not prevent an issuer from issuing life and AD&D coverage under a single policy. Any required rate filing must be consistent with the form as filed, including the range of variability the issuer chooses to specify.

Comment. One commenter asks for clarification concerning the requirements in §3.18. First, the commenter asks for guidance on how to comply with the requirement in subsection (a) that requires the variable material in the form to include specimen language or fill-in material that reflects the most restrictive option. Next, the commenter asks TDI to clarify in subsection (c) that illustrative items like eligibility provisions will be permitted, because the group market needs broad variability in the eligibility provisions. The commenter also asks whether variability is permitted within insert pages and matrix forms.

Agency Response. The requirement for specimen language and fill-in material to reflect the most restrictive option available under variability is a requirement of the former rules being repealed, under §3.4(d)(1). The bracketed language in the filed form should reflect the most restrictive option, if applicable. For example, a bracketed benefit amount should be the minimum benefit amount in the filed range; a bracketed deductible should be the maximum deductible amount in the filed range. The statement of variability should explain the full range and increments by which the amounts might vary. TDI agrees that variability in eligibility provisions is appropriate, as long as the filing demonstrates compliance with applicable requirements, and has changed the proposed rule text of

§3.18 to add new subsection (c)(5) to clarify that options selected by a group policyholder may vary according to clearly specified options. The rule does not prohibit the use of variability in an insert page or matrix form.

Comment. Two commenters raise concerns that the provisions in §3.18(d)(5) and (h) could (1) be applied inconsistently based on individual reviewers' judgment and understanding of the product, (2) require carriers to submit every possible plan design, and (3) result in carriers offering fewer plan options. One commenter states that TDI lacks statutory authority for subsection (h). The commenters note that some filings have broad variability encompassing thousands of permutations for plan designs to give group policyholders the ability to customize their products and that it would be overly burdensome for carriers to file and for TDI to review these individually. Both commenters suggest removing §3.18(d)(5), and one commenter suggests removing §3.18(h). The other commenter asked for clarification on whether under §3.18(h) TDI would expect a carrier to provide exhaustive examples of every possibility, or just a select sampling.

Agency Response. TDI disagrees that these provisions will negatively impact issuers or consumers and declines to make a change. Issuers are obligated to provide a clear explanation of how the material will vary, and TDI is obligated to ensure forms comply with applicable requirements. Section 3.18(d)(5) makes clear that TDI cannot approve a form without a full understanding of how the product will appear when issued. Most uses of variability are straightforward, and most issuers already provide sufficient explanations of variable material; therefore most issuers will not be affected by these provisions. However, when the approach to variability is unusual or particularly complex (such as when there are brackets within brackets that cause an interaction between variable text), subsection (h) gives reviewers another tool to aid in understanding how the product will function by requesting one or more examples of how the form will look when issued to

the consumer. This provision does not require issuers to provide exhaustive examples of every permutation contained in the form or reduce the range of variability included.

TDI also disagrees with the commenter's statement that limits on variability are not authorized by statute. The Insurance Code requires issuers to file forms subject to TDI review and approval and does not contemplate the use of variability. Variability is a privilege that is created by rule subject to TDI discretion. Like exempt filings, proper use of variability creates efficiency for both issuers and TDI while creating minimal compliance risk. The requirements in §3.18 seek to balance the dual aims of efficiency and thorough compliance reviews.

Comment. One commenter recommends changes to §3.18(e) and (f) to apply the requirements only to individual life insurance products.

Agency Response. TDI agrees in part, and has changed §3.18(e) as proposed to apply only to individual life and annuity products. TDI declines to change §3.18(f), which applies to both group and individual life and annuity products.

Comment on §3.20. Plain Language and Readability Requirements.

Comment. One commenter suggests changing §3.20(e)(7)(D) to use the term "unreasonably" in place of "unnecessarily" in the provision that states that it is a plain language best practice to avoid referring an insured between sections of a form.

Agency Response. TDI agrees to make the change.

Comments on §3.21. Group Filings.

Comment. One commenter supports changes to group filings, especially removing the requirement to submit separate form filings for each group type. The commenter states that this change will dramatically improve speed-to-market for applicable product types

in the Texas market. The commenter also asks for clarification about §3.21(a)(3), which the commenter believes is inconsistent with the proposal's statement that separate forms will not be needed for each group type.

Agency Response. TDI appreciates the support for this change. TDI disagrees that §3.21(a)(3) is inconsistent with the removal of the "one group, one filing" provision. Subsection (a)(3) requires issuers to submit form filings separately from group eligibility filings; it does not require separate forms for different group types. For example, a single group form filing could be made for a product that will be issued to an employer under §1251.051 and a trust under §1251.053. The group eligibility filing required under §3.21(c) for the trust should be submitted separately from the form filing.

Comment. One commenter asks whether §3.21(c) requires issuers to include copies of previously approved forms if the filing IDs and form numbers are provided. The commenter also states that §3.21(d) requires additional filings for a multiple association trust if any new association is added. The commenter states it would be overly complicated to require a complete new filing and recommends that previously approved documents be filed as informational rather than for approval.

Agency Response. Under §3.21(a)(3) and (c), a group eligibility filing is made separate from a form filing, and the only forms required within a group eligibility filing for a trust are alternate face page forms referenced in §3.21(c)(2). The forms that have been previously approved should be referenced as described in §3.21(c)(3)(B).

Comment. One commenter notes that §3.21(g) refers to statutes that mention "other groups," asks why it is necessary to mention these statutes in rule, and asks TDI to clarify that the rule does not require group eligibility filings for educational institutions.

Agency Response. TDI has observed that some issuers are uncertain about how to classify group filings for educational institutions, since educational institutions are not specifically identified by statute as eligible group policyholders. Because of this confusion, TDI includes §3.21(g) to explain that such filings are permitted under the "other groups" statutes and should be classified accordingly. Insurance Code §1131.064 and §1251.056 permit other types of group policyholders subject to a commissioner determination. Group eligibility filings are required for "other groups"--including educational institutions--under §3.21(e) so that TDI can determine whether the "other group" satisfies the statutory criteria. This is consistent with statute and current practice. TDI declines to exempt educational institutions from group eligibility filings because doing so is not supported by statute.

Comment. Two commenters oppose §3.21(h) and TDI's long-standing application of extraterritorial application of Texas law. The commenters outline legal arguments for why they believe it is inappropriate and unconstitutional for TDI to apply Texas requirements to coverage issued to Texas residents under policies issued to out-of-state group policyholders. The commenters ask why it is necessary for issuers to file out-of-state group documents in addition to the certificate that will be issued in Texas.

Agency Response. TDI declines to make a change. Insurance Code Article 21.42 provides that "any contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance, and governed thereby, notwithstanding such policy or contract of insurance may provide that the contract was executed and the premiums and policy (in case it becomes a demand) should be payable without this State, or at the home office of the company or corporation issuing the same." *See Howell v. Am. Live Stock Ins. Co.*, 483 F.2d

1354, 1360 n.4 (5th Cir. 1973) (stating in the context of group policies, "the fact that the insurer does any business in Texas is sufficient to require that Texas law apply to any contract between it and a Texas resident, regardless of the intention or expectation of the parties"); *General Am. Life Ins. Co. v. Rodriguez*, 641 S.W.2d 264, 266-67 (Tex. App.--Houston [14th Dist.] 1982, no writ) (holding Insurance Code Article 21.42 applies where group life policy issued to out-of-state employer covered employee residing in Texas).

Comments on §3.23. Acceptance, Rejection, and Disposition of Filings.

Comment. Three commenters submitted comments concerning the timeframe for requests for corrections. One commenter asks TDI to confirm that the intent of §3.23(b)(1) is to allow two business days to correct minor issues found during the intake process, and §3.21(c)(3) is to provide 10 business days to respond to reviewer objections on filed forms. The commenter also asks whether, under §3.23(c)(1)(A), TDI expects carriers to proactively request a 45-day extension or waiver of the deemer date, and whether TDI will advise of these options in their requests for correction. Two commenters recommend adding a provision to allow an issuer to waive the deemer period when the issuer needs more time to respond. The commenters note that for complex issues, companies sometimes need more than 10 days to submit corrections after a notice of deficiency to be too short of a timeframe and request additional rule text to ensure that issuers can request more time under §3.23(c). One of the commenters asks TDI to add language allowing the issuer and to extend the timeframes under §3.23(c) on agreement by both parties, noting that this would give some flexibility while ensuring TDI can still hold issuers accountable when appropriate. One commenter states that the deadline of two business days for making corrections to an incomplete filing under §3.23(b) is too short--noting that sometimes submitters may be out of the office on planned or unplanned leave. The commenter suggests changing the deadline to five or 10 business days.

Agency Response. TDI confirms that §3.23(b) gives issuers two business days to make technical corrections to avoid rejection of an incomplete filing, and §3.23(c)(3) gives issuers 10 business days to correct substantive compliance deficiencies. TDI declines to increase the timeframe for submitting corrections under §3.23(b) because the issues are usually easily corrected, and issuers are already meeting these timeframes under existing processes. TDI expects issuers to ensure their filing packages are complete upon submission and have backup staff available to promptly handle any issues. If there are more substantive issues that require more time to correct, the issuer should withdraw the filing and resubmit it when it is complete and ready for review. For substantive corrections during review requested in §3.23(c), paragraph (1) already permits issuers to request an extension or waive the deemer period, so no change is needed. TDI will maintain its current practice of advising issuers of the need to extend or waive a deemer date. TDI agrees to modify paragraph (3) to clarify that TDI may agree to extend the 10-day period for the issuer to submit corrections. This aligns with TDI's current process of granting reasonable extensions on request.

Comment. Two commenters ask for clarification on the meaning and timing of status changes during the filing review process. One commenter notes the prohibition under §3.23(a) on adding new forms after a filing has been accepted and asks how the carrier will know when the filing is in an "accepted" status. Another commenter notes that §3.23 does not address reopening a filing that has been rejected or disapproved and assumes that the issuer can resubmit such filings.

Agency Response. A filing is accepted after TDI confirms that it meets the filing requirements in this subchapter. TDI will review its procedures for using status codes in SERFF to help issuers understand when a filing has been accepted. TDI does not allow a

filing to be reopened after it has been rejected or disapproved. An issuer can resubmit the filing after the previous deficiencies have been corrected.

Comment. One commenter opposes the wording in §3.23(e), which states, "Before withdrawing approval, the department will provide notice and opportunity for hearing." The commenter believes the rule is inconsistent with Insurance Code Chapter 1701, which references that the "commissioner" may withdraw approval "after notice and hearing." The commenter expresses concern that using the word "department" reflects broad delegation not authorized by statute, and that the word "opportunity" does not appear in the express statutory requirements.

Agency Response. TDI declines to make a change to §3.23(e) because it is substantially similar to the wording in former §3.7(e)(2) and consistent with the use of the word "department" throughout the rule. Delegation of authority for specific functions, as addressed in Insurance Code Chapter 36, is outside the scope of this rule. TDI believes it is appropriate to give the issuer the opportunity to request a hearing, rather than to obligate issuers to attend a hearing that they may prefer to forego.

Comments on §3.40. Applications Generally.

Comment. One commenter asks whether §3.40 is intended to apply to enrollment forms in the group insurance market. The commenter also asks TDI to change §3.40(b) to clarify that it does not require issuers to file screenshots of electronic applications.

Agency Response. With respect to forms in the group insurance market, TDI does not broadly exempt "enrollment forms" because that term is not used consistently; in some cases, an enrollment form could be purely administrative, while in others the form has a substantive contractual purpose and would be subject to the rule as specified in §3.1(1).

TDI declines to change §3.40(b) but confirms the rule does not require the filing of screenshots--just the "text contained on the application."

Comment. Two commenters request removing §3.40(e)(1), which requires an application form to state that the application form will be attached to and become a part of the contract. One commenter finds this requirement to be excessive because that language is typically already included in the contract or policy the application is attached to. The commenter notes that this requirement would necessitate refiling of forms, which would be burdensome. Another commenter adds that there are cases where the entire contract does not become part of the policy.

Agency Response. TDI declines to remove §3.40(e)(1), because it is important for consumers to understand when filling out an application form that it will become a part of the contract upon completion. This requirement would apply only to applications filed after the rule's effective date, so it would not require refilings of previously approved applications. TDI agrees that applications are occasionally not attached to the contract and clarifies that the provision in §3.40(e)(1) applies only "if applicable."

Comment. One commenter notes that under §3.40(e)(3), an application form is required to include a method for an applicant to opt out of electronic communications. The commenter appreciates the rule referencing the statute that the ability of issuers to use an opt-out, rather than an affirmative consent for conducting business electronically.

Agency Response. TDI appreciates the support for this provision.

Comments on §3.41. Standards for Electronic and Telephonic Applications.

Comment. Two commenters note that §3.41(b) requires issuers to give an applicant a written copy of the completed application before the applicant is asked to sign and submit

the application. The commenters believe that this provision could be read to require a paper copy of applications completed telephonically or electronically. The commenters note that requiring a paper copy could conflict with Texas' enactment of the Uniform Electronic Transactions Act and the federal Electronic Signatures in Global and National Commerce Act, which give full legal recognition to electronic records. The commenters also note that the statutes referenced in §3.41(c) support an interpretation that the word "written" means an electronic record, and that issuers can comply with §3.41(b) by electronically providing a written copy of the completed application. The commenters ask TDI to clarify that the rule does not require delivery of a paper copy.

Agency Response. TDI confirms that an issuer can comply with §3.41(b) by electronically providing a written copy of the completed application.

Comment. One commenter states that §3.41(d), which requires disclosure of security procedures, is ambiguous and confusing. The commenter states that some states require submission of the application in the manner in which it is used and asks if this requires screen shots of electronic application platforms. The commenter notes that for applications accessed and submitted through an internet portal, this could require issuers to construct the portal and application before the application is approved, which would severely impair speed-to-market.

Agency Response. As stated in response to another comment, §3.40(b) does not require the filing of screenshots, just the "text contained on the application." TDI agrees to change the rule text as proposed to remove the requirement in §3.41(d) to include a description of security procedures with every filing of an application that will be used with electronic or telephonic transactions.

Comment on §3.50. Filing Requirements for Health Plan Disclosures.

Comment. One commentor states that it is unclear what is meant by the term "similar disclosure" or why it is needed in §3.50.

Agency Response. Similar disclosures would include other notices that are required to be filed in connection with health coverage. For example, if TDI had enforcement responsibilities for the federal Affordable Care Act, then the summary of benefits and coverage would also be filed under these provisions.

Comment on §3.51. Payment of Premiums or Cost Sharing.

Comment. Two commenters oppose §3.51 because it required major medical plans and Medicare Supplement policies to accept third-party payments. One commenter states that they are extremely concerned about this proposed requirement because of a history of bad actors abusing third-party payment schemes. The commenters state that the proposed language is broader than federal requirements and assert that TDI does not have statutory authority to adopt the provision, citing a frequently asked question posting (FAQ) on TDI's website that states that the issue is not addressed by statute. The commenters suggest that if the section is not removed, it should be modified to align with TDI's FAQ and simply require that issuers disclose in the contract any limitations that the issuer imposes on third-party payments.

Agency Response. To avoid any unintended consequences, TDI agrees with the commenters' suggestion to align the section with current practice. TDI has changed §3.51(a) as proposed to specify that any restriction on the form or manner of payment of premiums or cost-sharing must be specified in the contract. TDI has also changed subsection (b) as proposed to require issuers to provide consumers with reasonable options for paying premium and cost-sharing and not require payment by personal check. While the Insurance Code does not specifically address this issue, it is within TDI's

authority to adopt rules implementing Insurance Code Chapter 541. Also, Insurance Code §543.002 prohibits insurers from making an insurance contract or agreement relating to an insurance contract other than as expressed in the policy.

Comments on §3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage.

Comment. Two commenters request changes to §3.52 because the section requires issuers to submit a filing to TDI 180 days in advance, but it also addresses both a discontinuation that is subject to a 90-day notice and a refusal to renew that is subject to a 180-day notice. The commenters suggest bifurcating the requirements or clarifying that the 180-day notice applies only when an issuer is withdrawing from the market by refusing to renew all plans. One commenter states that it is inappropriate to apply this section to the discontinuance of Medicare Supplement plans under 28 TAC §3.3308.

Agency Response. TDI agrees with the commenters that a 180-day notice applies only to a refusal to renew all plans and has changed §3.52(a) as proposed to clarify that issuers must submit an informational filing to TDI through SERFF for each applicable line of business, without specifying the timeframe, since that is already addressed in other rules. TDI also changed §3.52(b) as proposed to clarify that it applies only to a filing when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area. No change is needed with respect to Medicare Supplement because those products are outside the scope of this section. Subsection (a) references 28 TAC §3.3038, which applies to individual major medical plans--not 28 TAC §3.3308, which applies to Medicare Supplement.

Comment on §3.61. Actuarial Information for Certain Accident and Health Filings.

Comment. One commenter suggests changing §3.61(e)(2) as proposed to "a new rate manual that includes base rates and rating factors used by the issuer."

Agency Response. TDI agrees with the commenter that a rating manual is acceptable but believes issuers should also have the option to provide rate sheets for each plan. To reflect both options, TDI has changed §3.61(e)(2) as proposed to clarify that issuers may file either new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer.

Comments on §3.4004. Exempt Forms.

Comment. One commenter believes that the proposed changes to §3.4004 do not impact existing policies that have previously been filed as exempt, and notes that it would be extremely disruptive to need to refile forms that have already been issued. The commenter asks TDI to add a provision to clarify that the rules apply only to filings made on or after the new effective date.

Agency Response. TDI agrees that the new rules will apply only prospectively but disagrees that additional rule text is needed.

Comment. Two commenters state that they do not understand why §3.4004(e)(1) is amended to no longer allow blanket forms to be filed exempt, and they ask whether there are particular concerns with certain products. For example, one of the commenters asks why an AD&D policy issued on a group basis would be exempt from review, while a similar AD&D policy issued on a blanket basis would need to be filed for review. The commenters also oppose §3.4004(f)(9), which disallows filing dental plans on an exempt basis. The commenters suggest that limits on filing dental products as exempt should apply only to

preferred provider dental plans and that stand-alone dental plans that do not include any kind of PPO or EPO should continue to be exempt.

Agency Response. TDI has identified blanket filings and dental filings as categories that frequently fail audit. TDI believes it will be more efficient for issuers for TDI to review these filings up-front, rather than to make subsequent filings to resolve compliance deficiencies. With respect to "preferred provider" dental plans, TDI notes that such structures are impermissible in Texas under Insurance Code §§1301.002, 1301.0042, and 1451.206. Despite the long-standing prohibition on these plan structures and the prohibition of filing products with preferred provider plan provisions as exempt, companies have continued to submit noncompliant exempt dental filings.

Comment. One commenter asks for clarification on what constitutes other fixed indemnity coverage that is more extensive than hospital indemnity, with reference to §3.4004(f)(7).

Agency Response. Hospital indemnity and other fixed indemnity products are recognized as distinct types of insurance. According to the product coding conventions used in SERFF, indemnity other than hospital is described as "an insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition." In contrast, hospital indemnity is described as "an insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition." To clarify, TDI has changed subsection (f)(7) as proposed to simplify the provision's wording.

Comment. One commenter notes that single premium immediate annuities are eligible to be filed exempt under §3.4004(c)(1), and asks whether single premium deferred group

annuities are also eligible to be filed exempt if they meet the criteria under subsection (c)(4). The commenter also asks for clarification with respect to contingent deferred annuities under subsection (d)(6), and asks whether TDI intends to require all forms to be filed for review and approval if they include deferred (as opposed to immediate) business.

Agency Response. Under §3.4004(c)(4), a single premium deferred group annuity may be filed exempt if it does not include persistency bonuses or additional interest credits of any time, waiver of surrender charges (with noted exceptions), two tier values, or market value adjustments. While some types of deferred annuities may be filed exempt, as specified in §3.4004(c), contingent deferred annuities must be filed for review and approval. A contingent deferred annuity is a special type of annuity product that is recognized as a distinct subtype of insurance. According to the product coding conventions used in SERFF, a contingent deferred annuity is "an annuity contract that establishes a life insurer's obligation to make periodic payments for the annuitant's lifetime at the time designated investments, which are not owned or held by the insurer, are depleted to a contractually defined amount due to contractually permitted withdrawals, market performance, fees and/or other charges."

Comment. One commenter noted that limited refilings for annuities are not specified in the exceptions listed in §3.4004(d), and asks for clarification on whether limited refilings that indicate a change in the mortality table or interest rates for new issues under the policy form are permitted to be filed exempt.

Agency Response. Limited refilings for annuity products are eligible to be filed exempt if they meet the criteria specified in §3.4004(c)(5).

Comment on §3.4009. Sanctions and Cancellation of Exempt Filing Privileges.

Comment. One commenter states that the removal in §3.4009 of an insurer's right to file exempt forms without any type of notice and right to a hearing is a violation of due process and Texas law in the Administrative Procedure Act. The commenter is concerned that the proposed amendments to §3.4009 give TDI broad authority to take actions that may be arbitrary and capricious and could result in cancellation for errors that may be inconsequential or inadvertent. The commenter suggests that §3.4009 should reference an insurer's due process right to notice and hearing before the exempt filing privilege is revoked.

Agency Response. TDI disagrees that §3.4009 would allow an issuer's exempt filing privilege to be canceled without notice and an opportunity for a hearing. Notice of a cancellation of exempt filing privilege would be contained in the failed audit notice. TDI has changed §3.4009 as proposed to note that if an issuer disagrees with TDI's determination it may request a hearing and to clarify that the failed audit notice is addressed in §3.4008 instead of §3.23.

Subchapter A. Submission Requirements for Filings and Departmental Actions Related to Such Filings
Repeal of §§3.1 - 3.8

STATUTORY AUTHORITY. The commissioner adopts the repeal of §§3.1 - 3.8 under Insurance Code §§1111A.015, 1153.005, 1701.060, and 36.001.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.1. Scope.

§3.2. Definitions.

§3.3. Transmittal Information.

§3.4. General Submission Requirements.

§3.5. Filing Authorities and Categories.

§3.6. Certifications, Attachments, and Additional Information Requirements.

§3.7. Form Acceptance and Procedures.

§3.8. Effective Date.

Subchapter A. Submission Requirements for Filings and Departmental Actions Related to Such Filings

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

STATUTORY AUTHORITY. The commissioner adopts new §3.1 and §3.2 under Insurance Code §§35.0045, 541.401, 843.151, 1111A.015, 1153.005, 1201.006, 1251.008, 1271.004,

1271.253, 1501.010, 1651.004, 1651.051, 1652.005, 1652.051, 1652.052, 1652.103, 1698.051, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §35.0045 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 35.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Insurance Code Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plans provisions that are not otherwise specifically

authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.103 provides that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.1. Applicability and Scope.

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

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

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

(B) any other coverage document attached to or made part of a document described in subparagraph (A) of this paragraph;

(2) a rate filing submitted in connection with a form filing under this subsection or otherwise required to be filed under Division 5 of this subchapter (relating to Actuarial Filing Requirements), including a schedule of charges, actuarial memorandum, or change to rating methodology;

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

(4) a network filing submitted in connection with an HMO plan under Chapter 11 of this title (relating to Health Maintenance Organizations), a preferred or exclusive provider benefit plan under Subchapter X of this chapter (relating to Preferred and Exclusive Provider Plans), or a Medicare Select plan under §3.3325 of this title (relating to Medicare Select Policies, Certificates and Plans of Operation), including:

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

(B) provider directories;

(C) network configuration filings, including:

(i) new applications;

(ii) limited provider networks;

(iii) annual network adequacy report filings;

(iv) access plans;

(v) service area expansions or reductions; and

(vi) material modification to a network configuration;

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

(E) quality assurance program filings;

(5) a group eligibility filing, as specified in §3.21 of this title (related to Group Filings), including articles of incorporation, bylaws, constitution, or a trust agreement, policy face page, and any other documentation needed to demonstrate that a prospective group or blanket policyholder is eligible under Insurance Code Chapter 1131, Subchapter B, concerning Group and Wholesale, Franchise, or Employee Life Insurance: Eligible Policyholders; Insurance Code Chapter 1251, Subchapter B, concerning Group Accident

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

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

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

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

(C) reports, including reports required for Medicare Supplement in Chapter 3, Subchapter T of this title (relating to Minimum Standards for Medicare Supplement Policies) and Long-Term Care in Chapter 3, Subchapter Y of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy);

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

(E) Medicare SELECT plans of operation and amendments; and

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

§3.2. Definitions.

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

(1) Amendment or endorsement--A form that is not a rider that changes or modifies the provisions of an issued policy, certificate, contract, or evidence of coverage.

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

(3) Commissioner--The commissioner of insurance.

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

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

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

(7) Evidence of coverage--Any certificate, agreement, or contract, including a blended contract, that is issued by an HMO to an enrollee and states the coverage to which the enrollee is entitled, consistent with Insurance Code §1271.051, concerning Evidence of Coverage: Contract and Certificate Requirements.

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

(9) Failed audit--A finding made by the department, consistent with §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms) that a form filed in an exempt filing mode includes one or more compliance deficiencies.

(10) Filing--A document filed with the department under this subchapter, including a form filing, rate filing, advertising filing, group eligibility filing, network filing, or informational filing.

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

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

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

(14) Form number--A unique identifier printed at the lower left-hand corner composed of numbers or letters that is assigned to a unique form.

(15) General use--A filing classification that indicates that the filed forms will be used with other forms submitted in the filing or with previously approved or exempted forms for a certain product or products or a subset of a product or type (for example, an application that will be used with all life products, an application that will be used with all universal life products, an application that will be used with group life and accident and health products, or an application that will be used with major medical and dental products).

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

(17) Insert page--A form consisting of a page or section of a contract that has a unique identifiable form number and is used in combination with other forms to create a complete contract.

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

(19) Limited, partial refiling--A change to a previously approved or exempted life or annuity form that meets one or more of the criteria set forth in subparagraphs (A) - (D) of this paragraph:

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

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

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

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

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

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

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

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

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

(B) social security numbers;

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

(D) identification cards;

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

(F) health information about an individual.

(24) Product--A package of benefits with a discrete set of rating and pricing methodologies that will be offered to a consumer within a single policy, group agreement, evidence of coverage, certificate, or contract. In the case of health coverage, a product also includes a particular network type (such as HMO, point of service, preferred provider, exclusive provider, or indemnity).

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

(26) Resubmission--A filing submission type that contains corrections made to a form that was previously disapproved or for which approval has been withdrawn.

(27) Rider--A form that adds or expands benefits and becomes a part of the policy, group agreement, evidence of coverage, certificate, or contract.

(28) SERFF--The System for Electronic Rates & Forms Filing established by the NAIC.

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

(30) Substantially similar--A form that, except for minor changes that are clearly identified and described in an accompanying document, is identical to a form that the department previously approved and is still compliant with current statutes and regulations.

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

(32) Supplemental--A type of product that is specifically designed and issued to supplement other in-force coverage.

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

Division 2. General Filing Requirements
28 TAC §§3.10 - 3.23

STATUTORY AUTHORITY. The commissioner adopts new §§3.10 - 3.23 under Insurance Code §§541.401, 843.151, 843.154, 1111A.015, 1153.005, 1153.006, 1201.006, 1201.101, 1201.206, 1251.008, 1271.004, 1271.253, 1501.010, 1651.004, 1651.051, 1652.005, 1652.051, 1652.052, 1652.103, 1698.051, 1701.053, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 provides that the commissioner, within the limits provided by the section, prescribe the fees to be charged under Insurance Code §843.154.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.006 provides that TDI set a fee not to exceed $200 for a form or schedule filed under Insurance Code Chapter 1153.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing standards for the readability of individual accident and health policies.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement the chapter and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Insurance Code Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and

standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plan provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.103 provides, that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1701.053 provides that TDI collect a fee in an amount determined by the commissioner for the filing of the form of a document under Insurance Code Chapter 1701.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are

reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.10. Requested Filing Mode.

Requested filing mode. All filings must identify a requested filing mode as described in this section.

(1) Review and approval. The following types of filings must be submitted for review or approval:

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

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

(C) a group eligibility filing for review; and

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

(2) File and use. A form or rate filing may be submitted in a file-and-use mode only as permitted under Insurance Code §1701.052, concerning File and Use.

(3) Exempt. A form filing may be submitted in an exempt mode only as permitted under Insurance Code §1701.005, concerning Exemptions, and Subchapter Z of

this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review).

(4) Informational. A filing may be submitted in an informational filing mode as specified in §3.1(6) of this title or if paragraphs (1) - (3) of this section do not apply.

§3.11. Submission Requirements.

(a) All filings and supporting documentation within the scope of this subchapter must be submitted through SERFF.

(b) If the electronic system designated by the department experiences a system-wide outage for any reason, any applicable deemer date or due date for a company response is tolled until the outage is resolved. The department may designate an alternative submission method for filings and supporting documents during such an outage.

(c) Filings submitted to the department must provide complete and accurate information about the filing, include responsive information in all applicable SERFF fields, and include applicable responsive information that is not duplicative of SERFF fields in a transmittal checklist uploaded into SERFF as provided in the department's submission guide. Material information required to be submitted in an initial filing through SERFF fields and transmittal checklists will not exceed the following:

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

(2) the contact person information as required by §3.12 of this title (relating to Contact Person);

(3) an explanation of the purpose and use of the filing as required in §3.14 of this title (relating to Purpose and Use);

(4) a clear designation if the issuer would like to make confidential a specific form, rate, or document in the filing, consistent with §3.15 of this title (relating to Confidential Information in Filings);

(5) the information and certifications required in §3.16 of this title (relating to Certifications);

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

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

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

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

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

(D) requested effective date for the filing;

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

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

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

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

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

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

(iii) name of group policyholder, in connection with a group eligibility filing;

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

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

(10) in the case of a filing that will be used with previously approved or exempted forms, or other pending filings, a list of the following information in connection with the forms the filing will be used with:

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

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

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

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

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

(11) an explanation of any variable material as required by §3.18 of this title (relating to Variable Material); and

(12) the Flesch score for each submitted form, consistent with §3.20 of this title (relating to Plain Language and Readability Requirements).

(d) For a substantially similar, exact copy, substitution, or resubmission filing, the issuer must include the following information concerning how the forms in the filing relate

to the forms that were previously approved, exempted, disapproved, or withdrawn from approval, as applicable:

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

(2) a summary of the differences between the previously approved form and the new form, including a description of any deleted text and a clear identification of all changes with new or modified text redlined.

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

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

§3.12. Contact Person.

An issuer submitting a filing to the department must:

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

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

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

(A) designates the contact person for that filing;

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

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

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

§3.13. Filing Fees.

(a) For a form filing identified under §3.1(1) of this of this title (relating to Applicability and Scope), a fee of $100 is required, subject to the following exceptions:

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

(2) a fee of $50 is required for a resubmission of a previously disapproved form, or a form for which approval has been withdrawn;

(3) for a matrix filing, due to the ability to create multiple contracts or policies from matrix provisions, a fee of $50 per form is required, subject to a maximum fee of $500 per filing; and

(4) no fee shall be required for a substitution filing.

(b) For a rate filing made under §3.1(2) of this title that is separate from a form filing:

(1) a fee of $100 is required for a filing under Insurance Code Chapters 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance; 1651, concerning Long-Term Care Benefit Plans; and 1652, concerning Medicare Supplement Benefit Plans; and

(2) a fee of $50 is required for all other rate filings.

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

(d) Filing fees required under this section must be paid to the department using the electronic funds transfer system provided on SERFF.

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

§3.14. Purpose and Use.

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

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

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

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

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

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

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

(5) if applicable, whether the filing addresses a new program or initiative (for example, a value-added noninsurance benefit, or a steering or tiering program) and, if so, how the program will affect consumers and whether the program or initiative has been filed, approved, or disapproved in other states;

(6) if applicable, to whom the product is to be marketed, for example, specific group types or sizes, such as an annuity contract marketed to issue ages 25 - 60; or a health benefit plan that will issued on the exchange; and

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

§3.15. Confidential Information in Filings.

(a) Filings submitted under this subchapter are subject to Government Code Chapter 552, concerning Public Information, including any applicable exception from required disclosure under that chapter. Except as provided in subsection (b) of this section, each submitted filing, including any supporting information filed, will be open for public inspection through SERFF Filing Access (or a subsequent electronic system) as of the date of the filing.

(b) If an issuer believes a portion of the information required to be filed under this subchapter is confidential and excepted from disclosure under Government Code Chapter 552, the issuer must use the SERFF confidentiality function to mark as confidential each document that contains information that the issuer believes is confidential and excepted from disclosure.

(c) An issuer is not permitted to add password protection or encryption, or otherwise format a document in a manner that restricts:

(1) the department's ability to fully process, review, search, and save the document without a password or other decryption process; or

(2) the public's ability to view public information in SERFF.

(d) An issuer may not declare an entire filing confidential. Entire filings marked confidential will be rejected under §3.23(c) of this title (relating to Acceptance, Rejection, and Disposition of Filings).

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

(f) An issuer must not include an individual consumer's personally identifiable information in a filing, other than the name of a group policyholder that is included in a filing as required under §3.21 of this title (relating to Group Filings).

§3.16. Certifications.

(a) General certification - all filings. All filings must include the following certifications:

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

(2) the issuer is bound by the certification;

(3) the issuer is familiar with all statutes and regulations of this state and the United States that are applicable to the filing and certifies that to the issuer's best knowledge, information, and belief, the filing complies with those statutes and regulations;

(4) the individual making the certification has reviewed the filing and the information in the filing is true and correct;

(5) the form filed is not deceptive or misleading; and

(6) if applicable, the Flesch score of each form is accurately reflected and meets the requirements of §3.20 of this title (relating to Plain Language and Readability Requirements).

(b) Additional certifications. An issuer must include additional certifications as applicable and specified in Figure §3.16(b). An individual making a certification referenced in Figure §3.16(b) must also make the certifications required by subsection (a) of this section.

Figure §3.16(b):

Additional certifications required under 28 TAC §3.16.

Additional certifications required under 28 TAC §3.16.

Additional Certifications[1]	File and use[2]	Exempt[2]	Resubmission[3]	Substantially similar[3]	Exact copy[3]	Substitution[3]	Supplemental[3]	Matrix or insert page[3]
1. The form does not contain any provisions that fail to comply with corrections requested by the department under the same or another form number.	X	X	X					
2. The form has not been previously disapproved (including by withdrawal of approval or failed audit) by the department under the same or another form number, or the prior disapproval has been specifically disclosed in the filing.	X	X	X					
3. The issuer has reviewed the form to ensure it complies with any new requirements that were established after the date the previous form was approved.				X	X	X		
4. No changes have been made to the form other than those identified.			X	X	X	X		
5. The form meets the definition of an exact copy in 28 Texas Admin. Code §3.2.					X			
6. The original version of the form has not been issued or otherwise used in Texas and will not be issued or used in Texas at any time.						X		
7. The form will be marketed only as supplemental coverage.							X	
8. The final product created and issued using the forms will comply with all applicable requirements.								X
9. The form filed qualifies to be filed exempt consistent with 28 Tex. Admin. Code §3.4004.		X						
10. The form filed complies with the criteria for exempt forms specified in 28 Tex. Admin. Code §3.4005.		X						
11. The form filed does not contain any new, uncommon, or unusual provisions, conditions, or concepts as provided in 28 Tex. Admin. Code §3.4006.		X						
12. The insurer submitting the form has had a certificate of authority to do business in Texas for a period not less than two years as required in 28 Tex. Admin. Code §3.4007.		X						
13. The use of the form filed will be discontinued in the event of future changes in laws or rules that would prohibit the use of such forms.		X						

[1] More than one column may apply to a given filing.
[2] Exempt and File-and-Use are filing modes that may be used as specified in §3.10.
[3] Substantially similar, exact copy, substitution, resubmission, and supplemental are terms defined in §3.2.

(c) Certification requirements. A false certification made under this section is an offense under Insurance Code §841.704, concerning False Statement, Report, or Other Document; Criminal Penalty, and §843.464, concerning Criminal Penalty.

§3.17. Form and Rate Filing Requirements.

(a) Except as provided by subsection (b) of this section, for a form or rate filing, only one product (including all forms that will constitute the entire contract and their associated rates) may be submitted in a single filing. This does not prevent an issuer from filing a product that contains multiple types of benefits that will be issued in combination in a single contract if that combination otherwise complies with applicable requirements.

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

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

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

(2) the complete mailing address of the issuer.

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

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

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

(3) has the additional identifying form number requirements set forth in §3.5201 of this title (relating to Submission of Form and Rate Filings) if the form is

submitted under Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance.

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

(f) An amendment that is submitted to modify an existing form must be accompanied by a revised version of that form (with a new unique form number) that incorporates the contents of the amendment, unless the amendment does not apply to newly issued forms. After the 180th day following the date the revised version of the form is approved, for newly issued coverage, the issuer must use the revised version of the form, rather than the amendment.

§3.18. Variable Material.

(a) Variable material generally. As specified in this section, an issuer may file forms, advertising, or provider contracts using variable material to illustrate the ways an issued document may vary from the filed material. Any variable material must be identified using brackets and include specimen language or fill-in material that reflects the most restrictive option, if applicable, within the range of variability. Variable material may not be used in an issued form. The issued form must clearly state the actual benefits and contract terms.

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

(1) provides a clear explanation of how the material will vary for each variable option or range that appears in the brackets on the form; and

(2) demonstrates compliance with applicable requirements.

(c) Permitted uses of variable material. It is acceptable for an issuer to use variable material to illustrate:

(1) how a document may vary due solely to the age, sex, or classification of the insured or enrollee;

(2) the range of benefit levels or options that will be offered to consumers;

(3) nonsubstantive administrative items in the document, such as phone numbers, addresses, or third-party administrators;

(4) the type of group the policy will be issued to if different review standards do not apply based on the group type; and

(5) how a form may vary based on clearly specified options selected by a group policyholder.

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

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

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

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

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

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

(e) Fill-in material for individual life and annuity forms. Individual life and annuity forms must contain fill-in material for a 35-year-old insured. If the form is not issued at age 35, the fill-in material must contain the youngest issue age. If any form includes

reduced death benefits, the fill-in material must include the age with the greatest reduction in benefits at issue. The fill-in material must be for the longest premium-paying period available.

(f) Life and annuity standards.

(1) For life forms, the text and specifications of nonforfeiture assumptions cannot include variable material;

(2) For life and annuity forms, a zero entry in a range of values on the specifications page:

(A) is acceptable for tiering levels, expense charges, or other fees applicable under the contract; and

(B) is not acceptable for any benefit or credit provided for in the language of the contract.

(g) Changes to variability. Any change to a statement of variability is considered a change to the form itself and must be filed in conjunction with the form.

(h) Examples upon request. The department reserves the right to request that the issuer supplement its filing with examples of forms without variability, including examples of forms actually issued to consumers (with confidential information redacted).

§3.19. Matrix and Insert Page Forms.

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

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

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

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

(2) may use the same matrix provision or insert page form number within multiple products, provided the language is applicable to each product; however, any changes in the language to comply with the requirements for each product will require a unique form number; and

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

(b) An issuer may use an insert page to replace an existing page or section of a previously approved or exempted form if the replaced page or section has a unique form number that distinguishes it from the other pages of the form it is inserted in.

§3.20. Plain Language and Readability Requirements.

(a) Purpose. This section establishes plain language requirements and procedures to make contracts easier to read by the public and to remove language that may be unjust, deceptive, misleading, or unreasonably confusing.

(b) Applicability. This section applies to all forms that are filed under this subchapter and issued to consumers, except for:

(1) forms that are subject to Subchapter G of this chapter (relating to Plain Language Requirements for Health Benefit Policies); and

(2) group annuity products.

(c) Plain language. Forms must be written in plain language and organized in a manner to make it easy for consumers to understand.

(d) Flesch Reading Ease requirements.

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

(2) An issuer must include a statement of the Flesch score of the document when the form is submitted to the department. The department may require the submission of further information to verify compliance.

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

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

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

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

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

(5) the unnecessary use of prefixes and suffixes;

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

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

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

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

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

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

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

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

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

(g) Formatting. The form must:

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

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

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

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

§3.21. Group Filings.

(a) An issuer submitting a filing for a group policy, agreement, evidence of coverage, or contract must comply with the requirements in this section.

(1) An issuer must identify the specific group type the form is being filed under by indicating the applicable Insurance Code section, including:

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

(B) for accident and health insurance and HMO coverage, Insurance Code Chapter 1251, Subchapter B, concerning Group Accident and Health Insurance: Eligible Policyholders; or

(C) for accident and health insurance, Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders.

(2) If Texas resident members of a group will be eligible to obtain coverage under a product issued to a group type specified in subsections (b) - (f) of this section,

then an issuer must submit a group eligibility filing, as specified in those subsections, indicating:

(A) the name of the group;

(B) the products to be issued to the group;

(C) the associated form numbers to be issued to the group and filing IDs the forms were approved under; and

(D) either:

(i) information that demonstrates that the group is eligible; or

(ii) a reference to a previous filing ID submitted by the issuer that the group's eligibility was verified under if the filing was made within the past five years and there has not been a material change to the information submitted or the group's continued eligibility.

(3) Forms to be used with multiple groups must be submitted separately from the group eligibility filing. Forms to be used with a single group may be submitted separately or in conjunction with the group eligibility filing.

(b) For a product to be issued to an association under Insurance Code §1131.060, concerning Nonprofit Organizations or Associations; §1251.052, concerning Associations; §1251.053, concerning Funds Established by Employers, Labor Unions, or Associations; or §1251.358, concerning Association, the issuer must submit a group eligibility filing that includes:

(1) a copy of the association's constitution, bylaws, and articles of incorporation, or other formative or organizational documents regulating the conduct of the association's internal affairs;

(2) an alternate face page form that identifies the association, unless the forms are filed to be used with a specific association, in which case the association must be identified on the case-specific face page;

(3) identification of the types of coverage the issuer intends to offer the association; and

(4) information demonstrating that the association is an eligible group policyholder.

(c) For a product to be issued to a trust under Insurance Code §1251.053, the issuer must submit a group eligibility filing that includes:

(1) a copy of the trust agreement;

(2) an alternate face page form for each related industry group, with a unique form number; and

(3) for a product to be issued to associations participating in a multiple association trust:

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

(B) a reference to the unique filing ID or IDs in which the department previously confirmed that each participating association is an eligible group, consistent with subsection (b) of this section.

(d) An issuer that has received a determination for a filing to be issued to associations participating in a multiple association trust must make a group eligibility filing for information to notify the department of any subsequent additions of participating associations upon enrollment. The filing must include the documentation

required in subsection (c) of this section for each association that joins the trust after the initial filing.

(e) An issuer that intends to offer a product to a type of group or blanket policyholder that is not identified in statute as an eligible policyholder must submit a group eligibility filing that demonstrates the group's eligibility, consistent with Insurance Code §1131.064, concerning Other Groups, §1251.056, concerning Other Groups, and §1251.359, concerning Coverage for Other Risks. The issuer must also submit actuarial information as required in §3.61 of this title (relating to Actuarial Information for Certain Accident and Health Filings), as applicable.

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

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

(2) for an employer association filing:

(A) comply with all filing requirements set forth in Chapter 26 of this title (relating to Employer-Related Health Benefit Plan Regulations);

(B) specify whether the plan will cover small or large employer members; and

(C) specify whether the group is considered a bona fide employer association under §26.301 of this title (relating to Applicability, Definitions, and Scope).

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

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

§3.22. Braille and Non-English Filings.

(a) A filing that includes a copy of a form that is submitted in braille as an exact copy of a previously approved form, or that is submitted in a non-English language that is translated from a previously approved English language form, must include a certification as required under §3.16(b) of this title (relating to Certifications) that the form is an exact copy of the English version of the previously approved form.

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

§3.23. Acceptance, Rejection, and Disposition of Filings.

(a) Acceptance, approval, and exemption of filings. Upon submission, a filing will be accepted for preliminary review of compliance with the filing requirements in this subchapter. If the filing requirements in this subchapter have not been satisfied, the department will consider the filing incomplete and may reject the filing or request that the issuer make corrections. After a filing has been accepted by the department, an issuer is not permitted to expand the scope of a filing, such as by submitting additional forms for review, unless the department has instructed the issuer to do so.

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

(2) Date for exempt filings. As permitted under Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review), an issuer may submit a filing in an exempt mode. A filing closed with an exempt disposition is considered exempt as of the disposition date, unless the filing is rejected as provided in subsection (b) of this section.

Exempt filings are subject to audit as specified in §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms).

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

(b) Rejection of filings.

(1) If the department determines that a filing does not meet the requirements of this subchapter, the department will reject the filing as incomplete and notify the issuer of the reason for rejection or request that the issuer make corrections to the filing. If the issuer does not make corrections within two business days of the department's request for corrections, the department may reject the filing. A filing that is closed with a rejected disposition will not be considered to have been filed or accepted with the department for purposes of Insurance Code §§1153.106, concerning Rate Outside Certain Percentages of Presumptive Rate; 1271.102; or 1701.054, or this subchapter.

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

(A) is marked confidential in its entirety;

(B) contains an individual consumer's personally identifiable information in violation of §3.15 of this title (relating to Confidential Information in Filings);

(C) contains changes from the previous form that are not clearly identified; or

(D) contains a certification that is materially inaccurate.

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

(c) Request for correction.

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

(A) for an insurance filing, the issuer, as necessary and at least seven days before the date the filing is deemed approved (unless otherwise permitted by the department):

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

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

(B) for an HMO filing, consistent with §11.301 of this title (relating to Filing Requirements):

(i) the department notifies the issuer that the review period has been postponed; or

(ii) the issuer, as necessary and no less than seven days before the date the filing is deemed approved (unless otherwise permitted by the department), provides a waiver of the issuer's right to deem the filing approved.

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

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

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

(3) If an issuer fails to submit corrections to the department within 10 business days after the department provides a notice of any deficiencies and request for corrections, the department may consider the filing withdrawn from review by the issuer. The department will not give any withdrawn filing consideration unless the issuer resubmits it as a new filing. Upon request from an issuer, TDI may agree to extend the 10-day period under this paragraph.

(d) Disposition. The department will send written or electronic notice of any actions taken by the department when it has completed the processing of the filing. The notice will state the disposition and its effective date.

(e) Withdrawal of approval. Before withdrawing approval, the department will provide notice and opportunity for hearing. The notice will specify each applicable form number and the compliance deficiencies.

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

Division 3. Requirements Relating to Application Form Filings
28 TAC §3.40 and §3.41

STATUTORY AUTHORITY. The commissioner adopts new §3.40 and §3.41 under Insurance Code §§35.0045, 541.401, 843.151, 1153.005, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §35.0045 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 35.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement the Insurance Code Chapter 1153.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including,

after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.40. Applications Generally.

(a) Application form filings must include an explanation of the purpose and use of the application that specifies:

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

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

(b) Application form filings must:

(1) include a form of the application that shows all text contained on the application, including all sections and questions that the applicant must complete, and any additional drop-downs, scripts, questions, questionnaires, or supplements that may be conditionally required on the basis of the applicant's responses; and

(2) clearly indicate which statements an applicant must agree to in order to be considered eligible for coverage.

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

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

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

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

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

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

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

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

(e) Application forms must:

(1) if applicable, clearly state that the application will become part of the contract;

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

(3) include a method for an applicant to opt out of electronic communications if the issuer does not seek affirmative consent for conducting business

electronically under Insurance Code §35.004, concerning Minimum Standards for Regulated Entities Conducting Business with Consumers; and

(4) if the issuer will obtain personal information on applicants from third parties, disclose the types of information that might be obtained, the circumstances when it might be obtained, and how it will be used.

§3.41. Standards for Electronic and Telephonic Applications.

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

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

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

Division 4. Requirements Specific to Accident, Health, and HMO Filings
28 TAC §§3.50 - 3.52

STATUTORY AUTHORITY. The commissioner adopts new §§3.50 - 3.52 under Insurance Code §§541.401, 843.151, 1201.006, 1202.051, 1271.004, 1301.007, 1501.010, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §541.401 provides that the commissioner may adopt reasonable rules as necessary to accomplish the purposes of Insurance Code Chapter 541.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1202.051 provides that the commissioner adopt rules necessary to implement the section and meet the minimum requirements of federal law.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1301.007 provides that the commissioner may adopt rules necessary to implement Insurance Code Chapter 1301.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement Insurance Code Chapter 1701.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.50. Filing Requirements for Health Plan Disclosures.

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

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

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

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

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

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

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

§3.51. Payment of Premiums or Cost Sharing.

(a) An issuer may not impose any restriction on the form or manner of the payment of premiums or cost-sharing for accident, health, or HMO coverage, unless the restriction is clearly disclosed in the application and the policy, certificate, or contract.

(b) A policy, certificate, or contract of accident, health, or HMO coverage must provide consumers with reasonable options for paying premiums and cost-sharing, and cannot require payment by personal check.

(c) Nothing in this section modifies the requirements or applicability of Insurance Code §1369.0542, concerning Effects of Reductions in Out-of-Pocket Expenses on Cost Sharing.

§3.52. Filings Required for Termination of Guaranteed Renewable Major Medical Coverage.

(a) Any issuer required to provide notice to the department related to a termination by discontinuance or refusal to renew all guaranteed renewable major medical coverage in a given market or service area under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions), §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association), §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market), or §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) must submit an informational filing to TDI through SERFF for each applicable line of business.

(b) A filing that is made under subsection (a) of this section when an issuer refuses to renew all guaranteed major medical coverage in a given market or service area must include:

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

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

(3) the number of covered lives affected in each Texas county;

(4) the effective date or dates the coverage will terminate on;

(5) a copy of the notices to be provided to policyholders, group contract holders, and enrollees; and

(6) a list of products that will be terminated that includes the form numbers and filing IDs.

(c) Filing requirements in this section are in addition to requirements in Chapter 7, Subchapter R of this title that may apply if the failure to renew coverage constitutes a withdrawal under Insurance Code Chapter 827.

Division 5. Actuarial Filing Requirements
28 TAC §§3.60 - 3.62

STATUTORY AUTHORITY. The commissioner adopts new §§3.60 - 3.62 under Insurance Code §§843.151, 1107.108, 1111A.015, 1153.005, 1153.103, 1201.006, 1201.206, 1251.008, 1271.004, 1501.010, 1651.004, 1651.051, 1651.053, 1651.055, 1652.005, 1652.051, 1652.052, 1652.101 - 1652.103, 1698.051, 1698.052, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1107.108 provides that the commissioner may adopt rules to implement the provisions of Insurance Code Chapter 1107.

Insurance Code §1111A.015 provides that the commissioner may adopt rules to implement Insurance Code Chapter 1111A.

Insurance Code §1153.005 provides that the commissioner, after notice and hearing, may adopt rules to implement Insurance Code Chapter 1153.

Insurance Code §1153.103 provides that the commissioner, after notice and a hearing, by rule may adopt a presumptive premium rate for various classes of business and terms of coverage regarding credit life insurance and credit accident and health insurance.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1251.008 provides that the commissioner may adopt rules necessary to administer Insurance Code Chapter 1251, subject to a notice and hearing as required by Insurance Code §1201.007.

Insurance Code §1271.004 provides that the commissioner may adopt rules necessary to implement the section and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1651.004 provides that TDI may adopt rules that are necessary and proper to carry out Chapter 1651.

Insurance Code §1651.051 provides that the commissioner by rule establish standards for long-term care benefit plans, and for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of these plans.

Insurance Code §1651.053 provides that the commissioner adopt rules to establish standards for loss ratios of long-term care benefit plans.

Insurance Code §1651.055 provides that the commissioner adopt rules to stabilize long-term care premium rates.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Insurance Code Chapter 1652, the commissioner adopt reasonable rules necessary and proper to carry out the chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides that the commissioner adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different plans, and may adopt reasonable rules that specifically prohibit benefit plans provisions that are not otherwise specifically authorized by statute and that the commissioner determines are unjust, unfair, or unfairly discriminatory.

Insurance Code §1652.052 provides that the commissioner adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

Insurance Code §1652.101 provides that the commissioner adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans.

Insurance Code §1652.102 provides that the commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

Insurance Code §1652.103 provides that the commissioner by rule provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

Insurance Code §1698.051 provides that the commissioner by rule establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal law.

Insurance Code §1698.052 provides that the commissioner adopt rules and provide guidance related to individual health plans, including qualified health plans, to address several factors, including covered benefits or health benefit plan design.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.60. General Actuarial Filing Requirements.

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

(1) Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance;

(2) Insurance Code Chapter 1107, concerning Standard Nonforfeiture Law for Certain Annuities;

(3) Insurance Code §1131.064, concerning Other Groups;

(4) Insurance Code §1153.101, concerning Filing of Schedule of Rates and Subchapter FF of this chapter (relating to Credit Life and Credit Accident and Health Insurance);

(5) Insurance Code §1251.056, concerning Other Groups;

(6) Insurance Code §1251.359, concerning Coverage for Other Risks;

(7) Insurance Code Chapter 1271, Subchapter F, concerning Schedule of Charges, and Chapter 11, Subchapter H of this title (relating to Schedule of Charges);

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

(9) Insurance Code Chapter 1651, concerning Long-Term Care Benefit Plans, and Subchapter Y of this chapter (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy);

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

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

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

§3.61. Actuarial Information for Certain Accident and Health Filings.

(a) This section applies to:

(1) individual accident and health products under Insurance Code §1701.057, concerning Withdrawal of Individual Accident and Health Insurance Policy Form Approval; and

(2) group accident and health coverage issued to alternative types of group policyholders under Insurance Code §1251.056, concerning Other Groups, and §1251.359, concerning Coverage for Other Risks.

(b) This section does not apply to rate filings specified in §3.60(9) - (11) of this title (relating to General Actuarial Filing Requirements).

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

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

(e) A new product filing must include the following actuarial information:

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

(2) new premium rate sheets for each plan or a rate manual that includes base rates and all rating factors used by the issuer;

(3) an actuarial memorandum that contains:

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

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

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

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

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

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

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

(f) A rate adjustment filing for an existing product must include:

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

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

(3) an actuarial memorandum that contains:

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

(B) scope and reason for the rate revision;

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

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

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

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

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

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

§3.62. Actuarial Information for Life and Annuity Filings.

(a) Each life filing that changes the nonforfeiture values of a particular policy or certificate must be accompanied by the information described in this subsection.

(1) For a life insurance product that is subject to Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance, an issuer must include an actuarial memorandum that demonstrates compliance with Insurance Code Chapter 1105.

(2) For a universal life filing, an issuer must include:

(A) an actuarial memorandum, signed by a qualified actuary, with a detailed and complete explanation of the basis for computing the policy value and the cash surrender value of the policy, including:

(i) the guaranteed maximum expense charges and loads;

(ii) the guaranteed interest rate or rates;

(iii) the guaranteed maximum mortality charges;

(iv) any other guaranteed charges; and

(v) any surrender or partial withdrawal charges;

(B) a comparison table for issue age 35 that displays columns of:

(i) the guaranteed death benefits;

(ii) guaranteed accumulated values;

(iii) cash surrender values; and

(iv) reserves for the policy; and

(C) itemized monthly universal life calculations for the first and 50th years showing:

(i) beginning values;

(ii) maximum expense charges;

(iii) maximum cost-of-insurance deductions;

(iv) monthly expense and/or policy fees;

(v) interest accumulations; and

(vi) the ending values for the specimen policy.

(3) For variable life forms, the issuer must provide actuarial information as required by §4.1504 of this title (relating to Insurance Contract and Filing Requirements), and as required by this section.

(4) The issuer must provide a certification that it will calculate all premiums, reserves, and nonforfeiture values in a manner consistent with the information submitted under this subchapter.

(b) For each annuity filing, an actuarial memorandum must be provided to meet the minimum requirements of Insurance Code Chapter 1107, concerning Standard Nonforfeiture Law for Certain Annuities, and specify the guaranteed interest rates, the maximum surrender charges, and any other maximum charges applicable in the determination of nonforfeiture values. If the issuer intends to change the guaranteed interest rates specified in the form, notification must be submitted to the department before the change. The notification must specify the new guaranteed interest rate and the

date when the new guaranteed interest rate will be effective for new issues of a specified policy form, as required by §3.1004 of this title (relating to Policy Form Review).

(1) For variable annuities, the actuarial information must include the information required in this subsection and the information required by §4.2105 of this title (relating to Contract Requirements) to the extent such material is applicable.

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

(A) identify the name of the separate account;

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

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

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

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

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

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

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

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

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies
28 TAC §3.3100

STATUTORY AUTHORITY. The commissioner adopts amendments to §3.3100 under Insurance Code §§1201.006, 1201.101, 1201.206, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing specific standards for the content and manner of sale of an individual accident and health insurance policy.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including,

after notice and hearing, rules that establish procedures and criteria relating to types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.3100. Policy Readability Generally.

(a) In order to increase policyholder understanding of individual accident and sickness policies, insurers are encouraged to draft individual accident and sickness policies in a readable manner. To maintain the value of the policy as a legal document, the utmost care and caution must be used in its preparation. Insurance Code Chapter 1201, Subchapter E, concerning Required Policy Provisions, requires the use of certain policy provisions in particular language or provisions that are as favorable to the insured or beneficiary as those set forth in that subchapter. Even with these requirements of law, insurers are encouraged to experiment with new language in these areas.

(b) The standards for plain language and readability set forth in Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) apply to forms filed under this subchapter.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies
Repeal of 28 TAC §3.3101 and §3.3102

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.3101 and §3.3102 under Insurance Code §§1201.006, 1201.101, 1201.206, 1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1201.101 provides that the commissioner adopt reasonable rules establishing specific standards for the content and manner of sale of an individual accident and health insurance policy.

Insurance Code §1201.206 provides that the commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to Insurance Code Chapter 1201 that are necessary, proper, or advisable for the administration of the chapter.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including,

after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

§3.3101. Organization of Policy Format for Readability.

§3.3102. Language Readability.

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

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.4004, 3.4005, and 3.4009 under Insurance Code §§1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including,

after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§3.4004. Exempt Forms.

(a) Group and individual life forms. The group and individual life insurance forms specified in this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, concerning Policy Forms, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (b) of this section:

(1) group and individual term life insurance forms;

(2) individual variable life policies with a separate account only;

(3) rider forms listed in subparagraphs (A) - (K) of this paragraph:

(A) accidental death benefit riders;

(B) waiver of premium riders;

(C) guaranteed insurability riders;

(D) individual retirement account (IRA) riders (to include Roth and Simple IRAs);

(E) preliminary term riders;

(F) conversion riders;

(G) exchange riders;

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

(I) dividend option riders;

(J) additional insured riders; and

(K) additional insurance on base insured riders;

(4) endorsement forms listed in subparagraphs (A) - (K) of this paragraph:

(A) optional retirement program (ORP) endorsements;

(B) nontransferability endorsements;

(C) H.R. 10 (Keogh plan) endorsements;

(D) tax sheltered annuity endorsements;

(E) nonassignability endorsements;

(F) settlement option endorsements;

(G) individual retirement account endorsements (to include Roth and Simple IRAs);

(H) unisex endorsements;

(I) loan endorsements;

(J) waiver of surrender charges on disability or confinement in a hospital or nursing home endorsements; and

(K) step-up or roll-up death benefit endorsements; and

(5) limited refilings for changes to the separate account for variable products.

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

(1) universal life, including flexible premium adjustable life;

(2) whole life;

(3) endowment life;

(4) variable life with a fixed account;

(5) business value;

(6) any forms containing a market value adjustment;

(7) deposit term;

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

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

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

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

(12) forms issued under the authority of Insurance Code §1131.064, concerning Other Groups, that are related to discretionary groups; or

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

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

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

(2) deferred annuities used as structured settlement options;

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

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

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

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

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

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

(7) reversionary annuities.

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

(1) annuities used to fund prepaid funeral contracts;

(2) variable annuities that contain guaranteed living benefit provisions;

(3) annuities that contain an index-linked crediting, long-term care, or other accident- and health-related benefit provision;

(4) applications for use with variable annuities, index-linked crediting annuities, annuities that contain a market-value-adjustment, or that contain a long-term care or other accident- and health-related provision;

(5) group annuity forms issued under the authority of Insurance Code §1131.064, relating to discretionary groups; or

(6) contingent deferred annuities.

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

(1) the group accident and health forms set out in subparagraphs (A) - (C) of this paragraph:

(A) a group accident and health form issued to employers under Insurance Code §1251.051, concerning Employers, or to a labor union or association of labor unions under Insurance Code §1251.052, concerning Associations;

(B) group forms issued under Insurance Code §§1251.051; 1251.052; or 1251.053, concerning Funds Established by Employers, Labor Unions, or Associations, respectively, that provide Medicare Supplement coverage to an employer, multiple employer arrangement, or a labor union and that are exempt from regulation under Insurance Code §1652.002(b)(1), concerning Medicare Supplement Benefit Plan;

(C) group forms issued under Insurance Code §1251.051 and §1251.052 that provide long-term care coverage to a single employer, a labor union, or an association of labor unions through a policy that is delivered or issued for delivery outside of Texas;

(2) group and individual accident and health forms that provide the following coverages:

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

(B) accidental death and dismemberment;

(C) hospital indemnity;

(D) vision;

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

(F) disability coverages (including income replacement, key-man, buy/sell, and overhead expense);

(G) policies designed to provide conversion coverages;

(H) other permitted coverages that are designed to supplement other in-force health insurance; and

(I) group stop loss/excess loss policies containing an attachment point of $5,000 or more.

(f) Exceptions. A filing identified in subsection (e) of this section is not permitted to be filed as exempt for any of the following insurance forms or rates:

(1) a group or individual health insurance policy that provides, on a comprehensive basis for illness and injury, a combination of hospital, medical, and surgical coverages, including any guaranteed renewable or short-term limited-duration major medical policies;

(2) a Medicare supplement policy as defined in Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, except as specifically provided in subsection (e)(1)(C) of this section;

(3) a long-term care policy as defined in Insurance Code Chapter 1651, concerning Long-Term Care Benefit Plans, (including any policies providing nursing home or home health care coverages), except as specifically provided in subsection (e)(1)(D) of this section;

(4) a form containing preferred provider or exclusive provider benefit plan provisions as defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans;

(5) a group form that is issued under Insurance Code §1251.056, concerning Other Groups;

(6) a conversion policy subject to the provisions of Chapter 21, Subchapter SS of this title, (relating to Continuation and Conversion Provisions), except for policies providing conversion from a policy included as an exempt form in this section;

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

(8) rate or actuarial information that is required to be filed, even if the form is filed exempt as permitted by this section; and

(9) a dental policy.

(g) Copies of previously approved forms. Except for filings not eligible to be filed exempt under subsection (f)(4) of this section, a form not otherwise exempted under this subchapter that is an exact copy of a form is exempt from the review and approval requirements of Insurance Code Chapter 1701. These forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(h) Copies of previously approved forms subsequently submitted in braille or a non-English language. Any form not otherwise exempted under this subchapter that is submitted in braille as an exact copy of a previously approved form, or any form that has

been translated into a non-English language from its previously approved English version, is exempt from the review and approval requirements of Insurance Code Chapter 1701. These forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter.

§3.4005. General Information.

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

(b) Insurers must cause all forms to comply with all required provisions of all applicable law, including the Insurance Code and the rules and regulations of the department. In addition to other legal requirements:

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

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

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

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

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

(1) The certifications for exempt filings required in §3.16 of this title (relating to Filing Modes, Categories, and Certifications).

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

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

(A) that the filing is exempt;

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

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

§3.4009. Sanctions and Cancellation of Exempt Filing Privileges.

(a) The privileges under this subchapter that permit an insurer to make exempt filings may be canceled if the insurer makes an exempt filing that fails to comply with one or more provisions of this title or the Insurance Code that results in the department determining that the filing has failed audit. If the issuer disagrees with TDI's determination under this section, it may request a hearing. The department will issue a notice of failed audit consistent with §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms) that explains:

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

(2) the corrective action required;

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

(4) how those privileges may be reinstated.

(b) If an insurer's privileges to make exempt filings under this subchapter are cancelled, the insurer is required to file for review and approval any and all forms intended for use in Texas, until the privileges under these sections are reinstated.

(c) Reinstatement of any privilege canceled under these sections will occur after a period of not more than one year, as provided in the notice of failed audit under subsection (a) of this section. An insurer may make application for reinstatement prior to the passage of the period specified in the notice of failed audit under subsection (a) of this section.

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

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

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.4020 under Insurance Code §§1701.057, 1701.060, 1701.061, and 36.001.

Insurance Code §1701.057 provides that the commissioner, in accordance with Insurance Code §1201.007, adopt reasonable rules necessary to establish standards for the withdrawal of approval of an individual accident and health insurance policy form.

Insurance Code §1701.060 provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria relating to review and approval of types of forms.

Insurance Code §1701.061 provides that the commissioner may adopt rules to implement the section, including rules to determine which noninsurance benefits are reasonably related to the types of insurance subject to Insurance Code Chapter 1701, ensure that noninsurance benefits are not unfairly deceptive or do not constitute a prohibited inducement, and address application of other chapters of the Insurance Code to noninsurance benefits.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

§3.4020. Appendix.

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on March 28, 2025.

Signed by:
Jessica Barta
5DAC5618BBC74D4...

Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §3.3100, §3.4004, §3.4005, and §3.4009; new 28 TAC §3.1, §3.2, §§3.10 - 3.23, §3.40, §3.41, §§3.50 - 3.52, and §§3.60 - 3.62; and the repeals of 28 TAC §§3.1 - 3.8, §3.3101, §3.3102, and §3.4020 are adopted.

Signed by:
FC5D7EDDFFBB4F8...

Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2025-9229