Relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws.

Compiler's Note: Section 5(b) of Act 147 of 2002 provided that Act 284 is repealed insofar as it is inconsistent with Act 147.

Compiler's Note: Section 301(a)(7) of Act 58 of 1996, which created the Department of Community and Economic Development and abolished the Department of Community Affairs, provided that the Community Development Block Grant Program under Act 284 is transferred from the Department of Community Affairs to the Department of Community and Economic Development.

Compiler's Note: Section 301(a)(16) of Act 58 of 1996 provided that all other powers and duties delegated to the Department of Community Affairs not otherwise expressly transferred elsewhere by Act 58 and currently performed by the Department of Community Affairs under Act 284 are transferred from the Department of Community Affairs to the Department of Community and Economic Development.

Compiler's Note: Section 401(b) of Act 198 of 1990 provided that the provisions of The Insurance Company Law of 1921 that have not been repealed by Act 198 shall control over the provisions of Title 15.

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Section 1. Be it enacted, &c., That the laws providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund, are hereby amended, revised, and consolidated as follows:

ARTICLE I.

PRELIMINARY PROVISIONS.

Section 101. Certain Words Defined.--The word "company," as used in this act, shall be construed to include incorporated insurance companies only, and title insurance companies, whether incorporated under the laws of this Commonwealth, or any other state, territory, or district, or under the laws of any foreign country.

Except where otherwise indicated, the word "association," as used in this act, shall be construed to include only individuals, partnerships or associations of individuals, authorized to engage in the business of insurance in the Commonwealth as insurers on the Lloyds plan.

The word "exchange," as used in this act, shall be construed to include only individuals, partnerships and corporations,
authorized by the laws of the Commonwealth to exchange with each other inter-insurance or reciprocal insurance contracts.

Section 102. Short Title.--This act shall be known and may be cited as "The Insurance Company Law of 1921."

Section 103. Scope of Act.--Except as in this act provided, the provisions of this act, in so far as they are applicable, shall apply: (a) To all domestic insurance companies incorporated under the provisions of this act; (b) to all domestic insurance companies incorporated under general or special laws since the thirteenth day of October, one thousand eight hundred and fifty-seven; (c) to all domestic insurance companies, heretofore incorporated, which have accepted the provisions of the Constitution and the general insurance laws enacted since the thirteenth day of October, one thousand eight hundred and fifty-seven; (d) to all domestic insurance companies, incorporated under any general or special law prior to the thirteenth day of October, one thousand eight hundred and fifty-seven, which, by the terms of their charters or the acts under which they were incorporated, hold charters subject to alteration or revocation; (e) to all other domestic insurance companies, incorporated by general or special law prior to the thirteenth day of October, one thousand eight hundred and fifty-seven, which accept the provisions of this act as hereinafter provided; (f) to all foreign insurance companies doing business in this Commonwealth; and (g) to all domestic and foreign associations and exchanges doing insurance business in this Commonwealth.

All insurance companies to which this act applies and which have the required capital and reserve may transact any one or more of the classes of insurance authorized by section two hundred and two (202) of this act in the same manner and to the same extent as insurance companies incorporated under the provisions of this act.

No insurance company heretofore created and to which this act applies shall be deprived of any right which it enjoys under its charter to engage in any business other than insurance. Nothing in this act shall be construed to interfere with the charter provisions or operations of any domestic mutual fire insurance company heretofore organized under any general or special law of this Commonwealth.


Section 105. Act Not To Apply to Certain Societies, Orders, and Associations.--This act shall not apply to assessment associations or to fraternal benefit societies, orders, or associations, having a lodge system with ritualistic form of work and representative form of government; or to beneficial and relief associations formed by churches, societies, copartnerships, associations, or corporations, with or without ritualistic form of work, the privileges and membership in which are confined to the members of such churches, societies, and to members and employees of such copartnerships, associations, or corporations.

Section 106. Power of General Assembly To Alter, Revoke, or Annul Charters.-- (106 repealed Dec. 19, 1990, P.L.834, No.198)

Section 107. Individuals, Associations, and Partnerships Prohibited from Doing Insurance Business.--Except as herein provided, the doing of any insurance business in this Commonwealth, as prescribed in this act, for insurance
companies, by any private individual, association, or partnership, is prohibited. Any person who solicits or obtains, within this Commonwealth, applications for insurance by any such private individual, association, or partnership, contrary to the provisions of this act, shall be liable to a penalty of one hundred dollars ($100.00), for the use of the Commonwealth, for every application obtained, to be sued for and recovered by the Attorney General or district attorney of the proper county, either by action of debt or criminal prosecution. Any person who has paid to any agent of such unauthorized individual, association, or partnership any premium moneys for insurance granted or to be granted shall be entitled to recover the same by an action at law from such agent or from the person, association, or partnership for which he acted. This section does not prohibit the doing of insurance business by associations known as Lloyds, nor the exchange of inter-insurance or reciprocal contracts of insurance authorized by this act, nor shall the same prevent any one from becoming and being accepted as personal surety or guarantor.

Section 108. Effect of Act on Existing Laws.--The provisions of this act, so far as they are the same as those of existing laws, shall be construed as a continuation of such laws and not as new enactments. The repeal by this act of any provision of law shall not revive any law heretofore repealed or superseded, nor shall such repeal affect any act done, liability incurred, or any right accrued or vested, or any suit or prosecution pending or to be instituted to enforce any right or penalty or punish any offense under the authority of the repealed laws. The provisions of this act shall not limit the jurisdiction and authority of the Office of Attorney General, including, but not limited to, the jurisdiction and authority granted pursuant to the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."
(108 amended July 9, 2008, P.L.885, No.62)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 109. Constitutionality.--The provisions of this act shall be severable, and, if any of its provisions shall be held to be unconstitutional, the decision of the court shall not affect the validity of the remaining provisions of this act. It is hereby declared as a legislative intent that this act would have been adopted by the General Assembly had such unconstitutional provision not been included therein.

ARTICLE II.
INCORPORATION OF INSURANCE COMPANIES.

Section 201. Classes of Insurance Companies.--Subject to the provisions of this act, insurance companies of any of the following classes may be incorporated: (a) Stock Life Insurance Companies; (b) Mutual Life Insurance Companies; (c) Stock Fire, Stock Marine, and Stock Fire and Marine Insurance Companies; (d) Stock Casualty Insurance Companies; and (e) Mutual Insurance Companies of any kind other than mutual life insurance companies.

Section 202. Purposes for Which Companies May Be Incorporated; Underwriting Powers.--(Hdg. amended May 22, 1945,
(a) Stock or mutual life insurance companies may be incorporated for any or all of the following purposes:
(1) To insure the lives of persons, and every insurance appertaining thereto; to grant and dispose of annuities; including variable life insurance contracts and variable annuity contracts under which values or payments or both vary in relation to the investment experience of the issuer or a separate account or accounts maintained by the issuer and to insure against personal injury, disablement, or death resulting from traveling or general accidents, and against disablement resulting from sickness, and every insurance appertaining thereto, when written as a part of a policy of life insurance. ((1) amended Dec. 13, 1974, P.L.951, No.313)
(2) To insure against personal injury, disablement, or death resulting from traveling or general accidents, and against disablement resulting from sickness, and every insurance appertaining thereto: Provided, That no life insurance company may be incorporated for the purposes mentioned in this clause unless it is also incorporated for the purposes mentioned in clause (1) of this subsection. ((a) amended Nov. 27, 1968, P.L.1118, No.349)
(b) Stock fire insurance companies may be incorporated for any or all of the purposes mentioned in paragraphs (1) and (2) of this subdivision; stock marine insurance companies may be incorporated for any or all of the purposes mentioned in paragraphs (2) and (3); and stock fire and marine insurance companies may be incorporated for any or all of the purposes mentioned in paragraphs (1), (2), and (3).

For making insurances--
(1) On dwelling houses, stores, and all kinds of buildings, and household furniture and other property,--against loss or damage, including loss of use or occupancy, by fire, smoke, smudge, lightning, and explosion, whether fire ensue or not, and by tornadoes, cyclones, windstorms, earthquakes, hail, frost, sleet, snow, or flood; against loss or damage by water to any goods or premises, arising from the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires, and of water pipes; against accidental injury to such sprinklers, pumps, or other apparatus; against loss or damage caused by the caving in of the surface of the earth above coal mines; against perils to property arising from the ownership or maintenance or from the use of aircraft, automobiles, or other motor vehicles; against loss or damage caused by bombardment, invasion, insurrection, riot, civil war, or commotion, and military or usurped power; and against damage to property as specified in this paragraph by any or all risks not herein specifically designated; and to effect reinsurance of any risk provided for in this clause. ((1) amended July 19, 1951, P.L.1100, No.245)
(2) Upon vessels, boats, cargoes, goods, personal property, merchandise, freight and other property,--against loss or damage by all or any of the risks of lake, river, canal, and inland navigation and transportation, including all personal property floater risks; upon automobiles, airplanes, seaplanes, dirigibles, or other aircraft, whether stationary or in operation or in transit, against loss or damage by fire, explosion, transportation, collision, or by burglary, larceny, or theft; not including, in any case, insurances against loss by reason of bodily injury to the person; and to effect reinsurance of any risk provided for in this clause. ((2) amended May 22, 1945, P.L.825, No.330)
(3) Upon vessels, freight, goods, wares, merchandise, specie, bullion, jewels, profits, commissions, bank notes, bills of exchange, and other evidence of debt, bottomry and respondentia interests, and every insurance appertaining to or connected with marine risks, and risks of transportation and navigation; and to effect reinsurance of any risk provided for in this clause.

(c) Stock casualty insurance companies may be incorporated for any or all of the following purposes:

(1) Guaranteeing the fidelity of persons holding places of public or private trust; guaranteeing the performance of contracts, other than insurance policies; guaranteeing the performance of insurance contracts, where surety bonds are accepted from insurance companies by States or municipalities in lieu of actual deposits; executing or guaranteeing bonds and undertakings required or permitted in all actions or proceedings or by law allowed; and indemnifying banks, bankers, brokers, financial or moneyed associations, or financial or moneyed corporations, against the loss of any bills of exchange, notes, drafts, acceptances of drafts, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts, bills of lading, documents, currency, money, gold, platinum, silver, and other precious metals, refined or unrefined, and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semi-precious stones, and also against loss resulting from damage, except by fire, to the insured's premises, furnishings, fixtures, equipment, safes and vaults therein, caused by burglary, robbery, holdup, theft, or larceny, or attempt thereof, except against loss caused by marine risks or risks of transportation or navigation: Provided, however, That indemnification against the loss of such property may include loss occurring during transportation by an armored motor vehicle accompanied by one or more armed guards. Also guaranteeing any Federal Land Bank against loss by reason of defective title or incumbrances on real property on which any such Federal Land Bank may make a loan secured by a mortgage.

(2) To insure against injury, disablement, or death resulting from traveling or general accident, and against disablement resulting from sickness, and every insurance appertaining thereto, including a funeral benefit to an amount not exceeding one hundred dollars.

(3) To insure against loss of, and damage to, glass, including lettering and ornamentation thereon, and the frame in which the glass is set, resulting from breakage of the insured glass.

(4) To insure any one against loss or damage resulting from accident to, or injury, fatal or non-fatal, suffered by any person for which the person insured is liable; to insure against medical, hospital, surgical and funeral expenses incurred by or on behalf of the persons accidentally injured, including the person insured; to insure against loss or damage to property caused by horses, or by any vehicle drawn by animal power, for which loss or damage the person insured is liable; and to insure against loss or damage to property, for which loss or damage the person insured is liable, but not including any kind of property damage insurance specified in other paragraphs of this section. Nothing in this paragraph shall apply to any kind of insurance against loss or damage resulting from the ownership, maintenance or use of a motor vehicle. Further, nothing contained in this paragraph shall apply to any kind of workmen's compensation insurance against loss or damage resulting from accident to, or injury, fatal or non-fatal, suffered by an
employe for which the person insured is liable or against medical, hospital, surgical and funeral expenses incurred by or on behalf of the employe accidentally injured as provided for in clause (14), subdivision (c) of section 202. ((4) amended July 9, 1976, P.L.948, No.184)

(5) To insure steam boilers, and pipes, flywheels, engines, and machinery connected therewith or operated thereby, against loss caused by explosion or accident; and against loss of or damage to life, person, or property resulting therefrom; and against loss of use and occupancy caused thereby; and to make inspection of, and issue certificates of inspection upon, such boilers, pipes, flywheels, engines, and machinery.

(6) To insure against loss or damage by burglary, larceny, theft, robbery, forgery, fraud, vandalism or malicious mischief (or any one or more of such hazards), and to insure against any and all kinds of loss or destruction of, or damage to, moneys, securities, currencies, scrip, coins, bullion, bonds, notes, drafts, acceptance drafts, bills of exchange, and other valuable papers or documents, except while in the custody or possession of, and being transported by, a carrier for hire or in the mail, and against loss or damage to automobiles and aircraft by burglary, larceny or theft, vandalism or malicious mischief, confiscation or wrongful conversion, disposal or concealment, whether held under conditional sale contract or subject to chattel mortgages, or otherwise, or any one or more of such hazards.

(7) To carry on the business of credit insurance or guaranty, either by agreeing to purchase uncollectible debts or otherwise; and to insure against loss or damage from the failure of persons indebted to the insured to meet their liabilities.

(8) To insure any goods or premises against loss or damage by water or other fluid, caused by the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires, or of other conduits or containers, or of water pipes, or caused by casual water entering through leaks or openings in buildings; and against accidental injury, from causes other than fire or lightning, to such sprinklers, pumps, water pipes, conduits, containers, or other apparatus; and against damage from use or occupancy of premises by reason of such loss or damage.

(9) To insure against loss or damage to elevators or other property, except loss or damage by fire, caused by the maintenance, operation, or use of elevators and machinery; loss or legal liability for damage to property resulting from such operation, maintenance, or use of elevators.

(10) To insure horses, cattle, and other live stock.

(11) To insure against loss or damage to motor vehicles and airplanes, seaplanes, dirigibles, or other aircraft (except loss or damage by fire or while being transported in any conveyance by land or water), including loss by legal liability for damage to property resulting from the maintenance and use of motor vehicles and airplanes, seaplanes, dirigibles, or other aircraft, to insure anyone against loss or damage resulting from accident to, or injury, fatal or non-fatal, suffered by another person, for which the person insured is liable resulting from the ownership, maintenance or use of a motor vehicle, to insure against medical, hospital, surgical and funeral expenses incurred by or on behalf of the persons accidentally injured as a result of the ownership, maintenance or use of a motor vehicle, including the person insured, and in the case of motor vehicle liability insurance, including also an obligation of
the insurer to pay disability benefits to injured persons and death benefits to dependents, beneficiaries or personal representatives of persons who are killed, irrespective of the legal liability of the insured when such insurance is issued with and supplemental to such liability insurance. ((11) amended Nov. 27, 1968, P.L.1118, No.349)

(12) To insure against loss or damage to machinery, pumps, transporting, hoisting and ventilating apparatus, and equipment of mines while located underground, and loss or damage to underground passageways, gangways, airways, drifts, slopes, shafts, overcasts, and stoppings in the mines:

Provided, however, That any casualty company which is authorized to transact business in this Commonwealth shall not expose itself to any loss or hazard on any one risk authorized by this paragraph in an amount exceeding ten per centum of its capital and surplus, unless it shall be protected in excess of that amount by reinsurance.

(13) To insure by means of an all-risk type of policy, commonly known as "The Personal Property Floater Policy," against all risks of loss of or damage to personal property owned by any individual other than merchandise, motor vehicles, aircraft, water-craft (excepting canoes, rowboats, sailboats less than twenty-one feet in length and outboard motor boats), or, personal property, pertaining to the business, trade or profession of the insured (excepting professional books, instruments and other professional equipment owned by the insured). ((13) added May 22, 1945, P.L.825, No.330)

(14) To insure against loss or damage resulting from accident to, or injury, fatal or non-fatal, suffered by an employe for which the person insured is liable and to insure against medical, hospital, surgical and funeral expenses incurred by or on behalf of the employe accidentally injured, including the person insured. ((14) added July 9, 1976, P.L.948, No.184)

((c) amended May 6, 1943, P.L.181, No.93)

(d) Mutual insurance companies of any kind, other than life insurance companies, may be incorporated for the following purposes:

(1) To make contracts of insurance, or to reinsurance and accept reinsurance, for any and all kinds of insurance, other than life insurance, which are not prohibited by statute or at common law from being the subject of insurance, but no such mutual company may transact any kind of insurance other than such as may be transacted by a stock company writing the same kinds of insurance. A mutual company possessing charter powers of clause (2), subsection (b) of this section, or clause (11), subsection (c) of this section shall not write assessable bodily injury and property damage liability insurance policies upon any automobiles or motor vehicles; except this prohibition shall not apply to insurance coverage providing for collision damage or other direct loss or damage to the insured automobile or motor vehicle; or a mutual company possessing the charter power of clause (14), subsection (c) of this section shall not write assessable workmen's compensation policies. All assessable policies shall have the words "This is an Assessable Policy" printed prominently on the backer or policy panel, as well as on the face of the policy in letters not less than sixteen point in size. ((1) amended June 19, 1981, P.L.94, No.33)

((d) amended Nov. 27, 1968, P.L.1118, No.349)

(e) Domestic stock and mutual insurance companies, other than life, and, if their charters permit, foreign companies, may transact any form of insurance not included in this section,
if such insurance is not contrary to law, and is allied or in harmony with the classes of insurance herein provided. Such additional insurance shall be transacted only on express license by the Insurance Commissioner and upon such terms and conditions as are from time to time prescribed by him.

(f) Domestic stock and mutual insurance companies, other than life or title, and, if their charters permit, foreign companies, may transact any or all of the kinds of insurance included in subdivisions (b) and (c) of this section upon compliance with all of the financial and other requirements prescribed by the laws of this Commonwealth for fire, marine, fire and marine, and casualty insurance companies transacting such kinds of insurance. ((f) amended Aug. 23, 1961, P.L.1078, No.486)

(g) Stock fire, stock marine, stock fire and marine, and stock casualty insurance companies may be incorporated for any or all of the purposes mentioned in subdivisions (b) and (c) of this section. ((g) added July 2, 1953, P.L.331, No.74) *

(h) (1) No domestic stock or mutual insurance company, other than life or title, shall issue a policy containing an aggregate limit on any one risk in an amount exceeding ten per centum (10%) of its capital and surplus, unless it shall be protected in excess of that amount by reinsurance or collateral. This collateral may be in the form of:

(i) Cash.

(ii) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets.

(iii) (A) Clean, irrevocable, unconditional letters of credit and credit agreements issued or confirmed by a qualified United States financial institution no later than the thirty-first day of December in respect of the year for which filing is being made and in the possession of the insurance company on or before the filing date of its annual statement.

(B) Letters of credit agreements meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as collateral until their expiration, extension, renewal, modification or amendment, whichever first occurs.

(iv) Any other form of collateral acceptable to the Insurance Commissioner.

(2) The term "qualified United States financial institution" when used in this subsection means an institution which meets the following qualifications:

(i) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof.

(ii) Is regulated, supervised and examined by United States Federal or state authorities having regulatory authority over banks and trust companies.

(iii) Has been determined by either the Insurance Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Insurance Commissioner.

((h) amended Feb. 17, 1994, P.L.92, No.9)
Section 203. Articles of Agreement.-- (203 repealed Dec. 19, 1990, P.L.834, No.198)

Section 204. Name of Company.--(204 repealed Dec. 19, 1990, P.L.834, No.198)

Section 205. Capital Stock; Payment of Subscriptions; Forfeiture of Partial Payment on Subscriptions.-- All payments on accounts of capital stock on any stock insurance company shall be made in lawful money or, subject to the limitations in the laws relating to insurance company investments, in securities publicly traded on a nationally recognized exchange (exclusive of stock issued in connection with an authorized merger or consolidation or as a stock dividend). Debt securities or preferred stock, in addition to being publicly traded on a nationally recognized exchange, must be rated as category 1 or 2 by the Securities Valuation Office of the National Association of Insurance Commissioners. No note or obligation given by a stockholder, whether secured by pledge or otherwise, shall be considered as a payment of any part of the capital stock. (205 amended Feb. 17, 1994, P.L.92, No.9)

Section 206. Minimum Capital Stock and Financial Requirements To Do Business.-- (a) Stock life insurance companies organized under clause (1) of subdivision (a) of section two hundred and two (202) of this act must have a paid up capital stock of not less than one million dollars ($1,000,000). Stock life insurance companies, organized under this act, for all of the purposes mentioned in subdivision (a) of section two hundred and two (202), must have a paid up capital stock of at least one million one hundred thousand dollars ($1,100,000). Every such company shall, in addition thereto, have a surplus paid in at least equal to fifty per centum of the subscribed capital stock. ((a) amended Nov. 27, 1968, P.L.1118, No.349)

(b) Stock fire, stock marine, and stock fire and marine insurance companies, organized under this act, for any of the purposes mentioned in either clauses (1) or (2) of subdivision (b), section two hundred and two (202), of this act, must have a paid up capital stock of not less than one hundred thousand dollars ($100,000); if organized for all the purposes mentioned in clauses (1) and (2) or in clause (3) of subdivision (b), section two hundred and two (202), of this act, two hundred thousand dollars ($200,000); and if organized for all of the purposes mentioned in clauses (1), (2), and (3) of subdivision (b) of section two hundred and two (202) of this act, four hundred thousand dollars ($400,000). Every such company shall, in addition thereto, have a surplus paid in at least equal to fifty per centum (50%) of the subscribed capital stock. ((b) amended Aug. 24, 1963, P.L.1157, No.493)

(c) Stock casualty companies, organized under this act for any of the purposes of insurance mentioned in subdivision (c) of section two hundred and two (202) of this act, must have a paid up capital stock of not less than seven hundred fifty thousand dollars ($750,000). Stock casualty companies organized under this act may undertake two or more classes of insurance

Compiler's Note: Section 2 of Act 33 of 1981, which amended subsection (d)(1), provided that Act 33 shall take effect immediately and no assessable policy upon automobiles and motor vehicles shall be written, issued, reissued or renewed on the 120th day next succeeding the effective date of Act 33 except this prohibition shall not apply to insurance coverage providing for collision damage or other direct loss or damage to the insured automobile or motor vehicle.
mentioned in subdivision (c) of section two hundred and two (202) of this act, by providing at least fifty thousand dollars ($50,000) paid up capital stock for each class of insurance; except that the paid up capital stock for credit insurance shall be one hundred thousand dollars ($100,000), and the paid up capital stock for fidelity and surety insurance shall be two hundred thousand dollars ($200,000); and except that the paid up capital stock in the case of insurance for the purposes mentioned in clause (11) subdivision (c) of section two hundred and two (202) of this act shall be five hundred thousand dollars ($500,000) and except that the paid up capital stock in the case of workmen's compensation insurance as provided for in clause (14) subdivision (c) of section two hundred and two (202) of the act shall be seven hundred fifty thousand dollars ($750,000). Any stock casualty company organized under this act to undertake two or more classes of insurance mentioned in subdivision (c) of section two hundred and two (202) of this act must have a paid up capital stock equal to the greater of seven hundred fifty thousand dollars ($750,000) or the sum total of the required capital paid up for each class of insurance for which the company is organized, and a company with a paid up capital stock of one million nine hundred fifty thousand dollars ($1,950,000) may transact all of the classes of insurance mentioned in subdivision (c) of section two hundred and two (202) of this act. Every such company shall, in addition thereto, have a surplus paid in at least equal to fifty per centum (50%) of the required paid up capital. (c) amended July 7, 1989, P.L.228, No.37)

(d) Companies organized under this act to insure lives on the mutual plan must have applications for insurance, to the amount of one million dollars ($1,000,000), by not less than four hundred persons. Companies organized under this act to insure lives on the mutual plan must also have a guarantee capital, before commencing business, of not less than two million dollars ($2,000,000), and shall maintain unimpaired a policyholders' surplus of one million dollars ($1,000,000) out of guarantee capital, surplus, or any combination thereof. (d) amended Dec. 18, 1992, P.L.1519, No.178)

(e) Mutual companies, other than mutual life companies and other than title insurance companies, which seek a certificate of authority to transact a line or lines of insurance business shall comply with the following conditions:

(1) Each such company shall hold bona fide applications for at least twenty (20) policies, to be issued promptly and simultaneously to at least twenty (20) policyholders or members upon not less than two hundred (200) separate risks, each within the maximum single risk described herein, upon the granting of the certificate of authority to do business.

(2) The "maximum single risk" shall not exceed three times the average risk or one percentum (1%) of the total insurance applied for, whichever is the greater.

(3) It shall have collected at least an annual cash premium upon each of such applications, which premium shall be held in cash in an interest-bearing account established in the name of the insurance company at financial institutions located in this Commonwealth. In the case of companies organized for any of the purposes mentioned in paragraphs (1) or (2) or (3) of subdivision (b) of section two hundred two of this act, the sum or sums of money advanced under section eight hundred nine of this act, shall amount to not less than twenty-five thousand dollars ($25,000) for the purpose mentioned in each numbered paragraph of subdivision (b). If organized for all of the
purposes mentioned in paragraphs (1), (2) and (3) of subdivision (b) of section two hundred two of this act, the sum or sums of money advanced under section eight hundred nine of this act shall amount to not less than fifty thousand dollars ($50,000). In the case of companies organized for any one of the purposes mentioned in subdivision (c) of said section two hundred two, except paragraphs (1), (4), (11) and (14), the sum or sums of money advanced under the said section eight hundred nine shall amount to not less than ten thousand dollars ($10,000) for the purpose mentioned in each numbered paragraph of said subdivision (c). In the case of companies authorized to issue non-assessable policies of insurance for the purposes mentioned in clause (11) or clause (14), subdivision (c) of section two hundred and two (202) of the act, the sum or sums of money advanced under the said section eight hundred nine shall amount to not less than seven hundred fifty thousand dollars ($750,000). For the purpose mentioned in either numbered paragraph (1) or (4) of said subdivision (c), such amount shall be not less than twenty-five thousand dollars ($25,000): Provided, That in no event shall a company be organized for any of the purposes mentioned in said subdivision (c) unless the sum or sums of money advanced under said section eight hundred nine shall amount to not less than fifty thousand dollars ($50,000); nor shall a company be organized for all of the purposes mentioned in said subdivision (c) except paragraph (11) or (14) unless the sum or sums of money so advanced shall amount to not less than three hundred fifty thousand dollars ($350,000).

(4) In the case of companies hereafter organized for the purposes mentioned in subdivisions (b) and (c) of section two hundred two of this act, each such company shall meet the requirements of paragraphs (1) and (2) of subdivision (e) of this section, and the required sum of money advanced under said section eight hundred nine shall not be less than the aggregate of the sums required under paragraph (3) of subdivision (e) of this section for the purposes for which the company is to be incorporated.

(5) For the purpose of transacting employer's liability and workmen's compensation insurance, the application shall cover not less than five thousand (5,000) employes, each such employe being considered a separate risk for determining the maximum single risk.

(6) Each company writing non-assessable policies shall maintain unimpaired so much of its surplus as is equal to the minimum capital required for stock companies authorized to transact the same class or classes of insurance; each company writing assessable policies shall maintain unimpaired fifty per centum (50%) of its required surplus.

((e) amended Dec. 18, 1992, P.L.1519, No.178)

(f) Every stock fire, stock marine, stock fire and marine, or stock casualty company, organized under this act for any or all of the purposes mentioned in both subdivisions (b) and (c) of section two hundred two of this act, must have paid up capital and paid in surplus of not less than the aggregate amount of paid up capital and paid in surplus required for such purpose or purposes of a stock fire, stock marine and stock fire and marine insurance company in subdivision (b) and of a stock casualty insurance company in subdivision (c) of this section.

(206 amended July 2, 1953, P.L.331, No.74)

Section 206.1. Exclusion from Minimum Financial Requirements.--(a) A fire or casualty company seeking a certificate of authority to do business in Pennsylvania shall
satisfy and continue to comply with the minimum capital and surplus requirements imposed by this act.

(b) An existing fire or casualty company with capital and surplus that satisfies the requirements imposed by this act shall comply and continue to comply with the requirements of this act.

(c) An existing fire or casualty company that has capital and surplus less than the minimum requirements imposed by this act shall be required to continue to comply with the minimum capital and surplus requirements imposed by this act as of January 1, 1989, and shall not be required to meet the minimum requirements of this act. However, an existing fire and casualty company must comply with the minimum capital and surplus requirements imposed by this act, if any of the following occurs:

(1) any change in charter powers expanding the lines of insurance the company is authorized to write, except for the limited purpose of issuing policies covering homeowners multiple peril, farmowners multiple peril, mobile homeowners multiple peril, personal liability and farmers personal liability;
(2) a merger or the acquisition of beneficial ownership of more than 10% of any class of such insurer's voting stock which requires a filing pursuant to section 337.6 of this act;
(3) a transaction under section 809 that results in a transfer of ownership, or acquisition of control of such insurer through purchase or assignment of a management contract; or
(4) a change in the majority of such insurer's board of directors as a result of a single event or series of related events.

(206.1 added July 7, 1989, P.L.228, No.37)

Section 206.2. Additional Capital and Surplus.--(a) In addition to the minimum capital and surplus required for an insurance company to qualify for authority to transact one or more of the classes of insurance set out in section 202 of this act, the Insurance Commissioner shall have the authority to require additional capital and surplus based upon the nature, type and volume of insurance a company is transacting or proposes to transact.

(b) Whenever the Insurance Commissioner believes, from evidence satisfactory to him, that an insurance company has failed to meet the capital and surplus required by this section, the Insurance Commissioner may, in his discretion:

(1) disapprove an insurance company's request for a certificate of authority, or amendment thereto; or
(2) otherwise restrict, as provided by law, a company's authority to transact business within this Commonwealth.

Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the company stating specifically the nature of the proposed action and within thirty (30) days from the date of mailing of such notice to the company, such company may make written application to the Insurance Commissioner for a hearing thereon, and such hearing shall be held within thirty (30) days after receipt of such application.

(206.2 added Dec. 18, 1992, P.L.1519, No.178)

Section 207. Duration of Charter.--(207 repealed Dec. 19, 1990, P.L.834, No.198)

Section 208. Officers and Directors.--(208 repealed Dec. 19, 1990, P.L.834, No.198)

Section 210. Certificate to Insurance Commissioner.--Whenever one-half of the capital stock and paid in surplus of any stock insurance company mentioned in the articles of agreement has been subscribed, and twenty percentum (20%) of the total subscription price on each share paid into the hands of the treasurer of the company, the president, treasurer, and a majority of the directors, shall, under their respective oaths or affirmations, make a certificate to the Insurance Commissioner stating: (a) The number and par value of the shares of stock in said company; (b) the names and residences of the subscribers; (c) the number of shares subscribed by each; (d) the amount paid in on each share; (e) the amount of money in the hands of the treasurer on account of such payments; and (f) where the same is deposited.

Whenever applications for insurance, in the case of a mutual insurance company, have been received in sufficient number and amount, the president, treasurer, and the majority of the directors of such company, shall, under their respective oaths or affirmations, make a certificate to the Insurance Commissioner stating: (a) The names and residences of the persons applying for insurance in such company; (b) the amount agreed to be taken by each; and (c) the amount of money in the hands of the treasurer.

In the case of mutual life insurance companies, in addition to the certificate above required, as soon as the guarantee capital has been subscribed, and fifty percentum (50%) thereof has been paid in lawful money to the treasurer and the subscribers' obligations given for the remaining fifty percentum (50%) thereof, the president, treasurer, and a majority of the directors, shall, under their respective oaths or affirmations, make a certificate to the insurance commissioner stating: (a) The number and par value of the shares of guaranty stock in said company; (b) the names and residences of the subscribers; (c) the number of shares subscribed by each; (d) the amount paid in on each share; (e) the form of obligations taken for the unpaid moiety; (f) the amount of money in the hands of the treasurer; and (g) where the same is deposited.


Compiler's Note: Section 401(b) of Act 198 of 1990 provided that section 210 is repealed insofar as it prohibits the use of shares without par value.

Section 211. Acknowledgment and Approval of Articles of Agreement; Letters Patent.--(211 repealed Dec. 19, 1990, P.L.834, No.198)


Section 214. Certain Information To Be Filed with the Auditor General; Penalty.-- (214 repealed Dec. 19, 1990, P.L.834, No.198)

Section 215. Examination of Companies; Certificate To Do Business.--(a) As soon as the entire amount of the authorized capital of a stock insurance company, incorporated under this act, has been paid in, certificates shall be issued therefor to the persons entitled to receive the same, which certificates shall be transferable upon the books of the company; and the president or secretary of the company shall notify the Insurance Commissioner that the entire capital stock and paid in surplus of the company has been paid in, and that it is ready to
commence business. Upon receipt of such notice, the Insurance Commissioner shall, in person or by deputy or examiners, examine the company; and, in case he finds that it has complied with the provisions of this act, and is possessed of funds, invested in the manner hereinafter specified, equal to the amount of its capital stock and paid in surplus, he shall issue to said company a certificate showing that it has been organized in accordance with the provisions of this act, and that it has the requisite amount of capital stock and paid in surplus for the transaction of business in the Commonwealth, which certificate shall empower the company to issue policies, and otherwise transact the business of insurance for which it was incorporated. (a) amended Aug. 24, 1963, P.L.1157, No.493)

(b) In the case of a mutual life insurance company incorporated under this act, upon the receipt of a notice from the president or secretary of such company, the Insurance Commissioner shall make an examination; and, if he finds that the necessary amount of insurance has been applied for, and that fifty per centum (50%) of the guarantee capital has been paid in and invested, less the necessary expenses of organization, and that obligations have been given for the remaining moiety of the guarantee capital, he shall issue a certificate authorizing the company to commence business.

(c) The Insurance Commissioner shall, upon the receipt of a notice from the president or secretary of any mutual company, other than a life company, incorporated under this act, make an examination of such company; and, if he finds that such company has complied with the provisions of this act, he shall issue a certificate authorizing the company to commence business.

The Insurance Commissioner may also conduct such examination of any proposed company, as may be deemed necessary, to determine whether the responsibility, character, and general fitness for the business, of the incorporators and directors, names in the articles, are such as to command the confidence of the public, and to warrant the belief that the business of the proposed company will be honestly and efficiently conducted, in accordance with the intent and purpose of this act.

(215 amended June 4, 1937, P.L.1639, No.339)

Section 216. Reports of Policy Cancellation to Department of Transportation.--(a) An insurer shall notify the Department of Transportation of the cancellation, lapse, rescission or nonrenewal of any policy of liability insurance or any bond held by or on behalf of an official vehicle inspection station in this Commonwealth in accordance with 75 Pa.C.S. § 4722 (relating to certificate of appointment). An official vehicle inspection station is, for purposes of this section, a commercial garage or similar facility certified by the Department of Transportation to conduct inspections of motor vehicles in accordance with 75 Pa.C.S. Ch. 47 (relating to inspection of vehicles).

(b) For purposes of compliance with this section, insurers shall include language on appropriate applications or renewals for applicants or insureds to indicate whether or not they are official vehicle inspection stations.

(c) This section shall not apply to "Commonwealth inspection stations" or "fleet inspection stations" as defined in regulations promulgated by the Department of Transportation.


ARTICLE III.
Section 300. Government Owned Companies.— (a) For purposes of this section, except when the context clearly indicates otherwise:

(1) "Insurance company" means an insurance company, association or exchange or any other entity subject to the jurisdiction of the Insurance Department.

(2) "Control" has the meaning prescribed in section 1401.

(3) "Government owned" means owned or controlled, directly or indirectly, by another state, territory or jurisdiction of the United States or by a foreign government or by any political subdivision, instrumentality or agency of either.

(b) A government owned insurance company shall not be admitted or authorized to do business in this Commonwealth until it has demonstrated and continues to demonstrate to the Insurance Commissioner's satisfaction that it:

(1) does not receive a subsidy or other competitive advantage as a result of such control or status that would enable it to compete unfairly with similarly situated authorized insurers which are not so controlled or constituted;

(2) is not entitled to claim sovereign or similar governmental immunity or has filed a waiver of sovereign or similar governmental immunity with the Insurance Commissioner;

(3) cedes no more than fifty per centum (50%) of its annual gross written premiums to assuming insurers that neither hold a certificate of authority nor are qualified reinsurers in this Commonwealth;

(4) maintains a policyholders' surplus of at least thirty-five million dollars ($35,000,000) or such other amount determined by the Insurance Commissioner calculated and reported in the manner prescribed by the department pursuant to section 320;

(5) is domiciled in a jurisdiction which has insolvency laws applicable to the insurance company that in law and application are fair, reasonable and not prejudicial to policyholders, creditors or the public generally;

(6) has filed with the Insurance Commissioner an irrevocable consent not to seek the protection of 11 U.S.C. § 304 (relating to cases and ancillary to foreign proceedings);

(7) its operation as an insurer would not be detrimental to the public interests of this Commonwealth;

(8) otherwise satisfies all applicable requirements for the issuance of a certificate of authority, including, but not limited to, reasonable standards of solvency, the deposit of security, the establishment of a special trust fund for the benefit of policyholders or other requirements as may be established from time to time by the Insurance Commissioner; and

(9) is in compliance with the requirements set forth in section 301.

Any entity granted a certificate of authority under the provisions of this section shall notify the Insurance Commissioner within five (5) business days of any material change with respect to clause (1), (2), (3), (4) or (5) of this subdivision or of any material order or other action affecting its certificate of authority.

(c) Upon satisfactory evidence of the violation of this section by an insurance company, the Insurance Commissioner may in the Insurance Commissioner's discretion pursue any one or more of the following courses of action:
(1) suspend or revoke the certificate of authority of such offending company;
(2) refuse for a period not to exceed one year thereafter to issue a new certificate of authority to such offending company;
(3) impose a penalty of not less than five thousand dollars ($5,000) nor more than twenty-five thousand dollars ($25,000) for each action in violation of this section.
(300 amended Dec. 21, 1998, P.L.1108, No.150)

Section 301. Requisites for Foreign Companies To Do Business.--No stock or mutual insurance company or association of any other State or foreign government shall be admitted and authorized to do business until:
(a) It has filed with the Insurance Commissioner a certified copy of its charter or deed of settlement, a statement of its financial condition and business, signed and sworn to by its proper officers, and copies of forms of all policies it proposes to issue in this Commonwealth, with such other information as he may require.
(b) It has satisfied the Insurance Commissioner that it is fully and legally organized under the laws of its State or government to do the business it proposes to transact. That it has, if a stock company, the requisite amount of capital fully paid up and unimpaired.
(c) It shall, by a duly executed instrument filed in his office, constitute and appoint the Insurance Commissioner or his successor its true and lawful attorney, upon whom all lawful processes in any action, rule, order, or legal proceeding against it may be served; and therein shall agree that any lawful process against it which may be served upon him as its said attorney shall be of the same force and validity as if served on the company, and that the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this Commonwealth.
(d) ((d) deleted by amendment July 10, 2002, P.L.749, No.110)
(e) It shall have actually engaged in doing an insurance business, by solicitation of insurance through agents, brokers or by mail; by assumption and underwriting of risks; by acceptance of applications for and issuance of and delivery of policies, certificates or contracts of insurance; by collection of premiums or assessments or their equivalent; by investigation, adjustment and payment of claims and losses; by filing annual financial statements and other reports and documents required by proper regulatory bodies or agencies and by complying with applicable statutory enactments, in its state of domicile for a minimum period of at least one year immediately preceding its seeking admission to this Commonwealth. The requirements of this clause may be partly or entirely waived by the Insurance Commissioner with respect to any company or association which is affiliated with one or more insurers already authorized in Pennsylvania. ((e) added Dec. 30, 1974, P.L.1050, No.344)

Section 301.1. Use of Name.--The Insurance Commissioner may prohibit the use, by any domestic stock or mutual insurance company or association and the use in this Commonwealth by any foreign or alien stock or mutual insurance company or association, of a name when, in his judgment, it too closely resembles that of an existing company or association authorized to do business in this Commonwealth or is likely to confuse or mislead the public. This section shall not prevent any company or association authorized to do business in this Commonwealth
on the effective date of this act from continuing thereafter
the use of its full correct name on such date.

(301.1 added Dec. 30, 1959, P.L.2060, No.751)

Section 301.2. Classes of Shares.--(301.2 repealed Dec. 19, 1990, P.L.834, No.198)

Section 302. Status of Shares of Stock; Rights of
Stockholders With Reference Thereto; Limitations on
Rights.--(302 repealed Dec. 19, 1990, P.L.834, No.198)

Section 302.1. Filing of Statement of Ownership of Shares
of Stock; Limitation of Rights.--(1) Every person who is
directly or indirectly the beneficial owner of more than ten
percent of any class of any equity security of a domestic stock
insurance company, or who is a director or an officer of such
company, shall file in the office of the Insurance Commissioner
on or before the first day of July, nineteen hundred sixty-six,
or thereafter within ten days after he becomes such beneficial
owner, director or officer a statement, in such form as the
Insurance Commissioner may prescribe, of the amount of all
equity securities of such company of which he is the beneficial
owner, and within ten days after the close of each calendar
month thereafter, if there has been a change in such ownership
during such month, shall file in the office of the Insurance
Commissioner a statement, in such form as the Insurance
Commissioner may prescribe, indicating his ownership at the
close of the calendar month and such changes in his ownership
as have occurred during such calendar month.

(2) For the purpose of preventing the unfair use of
information which may have been obtained by such beneficial
owner, director or officer by reason of his relationship to
such company, any profit realized by him from any purchase and
sale, or any sale and purchase, of any equity security of such
company within any period of less than six months, unless such
security was acquired in good faith in connection with a debt
previously contracted, shall inure to and be recoverable by the
company, irrespective of any intention on the part of such
beneficial owner, director or officer in entering into such
transaction of holding the security purchased or of not
repurchasing the security sold for a period exceeding six
months. Suit to recover such profit may be instituted at law
or in equity in any court of competent jurisdiction by the
company, or by the owner of any security of the company in the
name and in behalf of the company if the company shall fail or
refuse to bring such suit within sixty days after request or
shall fail diligently to prosecute the name thereafter; but no
such suit shall be brought more than two years after the date
such profit was realized. This paragraph shall not be construed
to cover any transaction where such beneficial owner was not
such both at the time of the purchase and sale, or the sale and
purchase, of the security involved, or any transaction or
transactions which the Insurance Commissioner by rules and
regulations may exempt as not comprehended within the purpose
of this paragraph.

(3) It shall be unlawful for any such beneficial owner,
director or officer, directly or indirectly, to sell any equity
security of such company if the person selling the security or
his principal (i) does not own the security sold, or (ii) if
owning the security, does not deliver it against such sale
within twenty days thereafter, or does not within five days
after such sale deposit it in the mails or other usual channels
of transportation; but no person shall be deemed to have
violated this paragraph if he proves that notwithstanding the
exercise of good faith he was unable to make such delivery or
deposit within such time, or that to do so would cause undue inconvenience or expense.

(4) The provisions of paragraph (2) of this section shall not apply to any purchase and sale, or sale and purchase, and the provisions of paragraph (3) of this section shall not apply to any sale, or an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The Insurance Commissioner may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

(5) The provisions of paragraphs (1), (2) and (3) of this section shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the Insurance Commissioner may adopt in order to carry out the purposes of this section.

(6) The term "equity security" when used in this section means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the Insurance Commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(7) The provisions of paragraphs (1), (2) and (3) of this section shall not apply to equity securities of a domestic stock insurance company if (a) such securities shall be registered, or shall be required to be registered, pursuant to the Federal Securities Exchange Act of 1934, as amended, or if (b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of paragraphs (1), (2) and (3) of this section except for the provisions of this subparagraph (b).

(8) The Insurance Commissioner shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him by paragraphs (1) through (7) of this section, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of paragraphs (1), (2), and (3) of this section imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Insurance Commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

(9) Any person violating any provision of this section shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to pay a fine not exceeding five hundred dollars ($500.00) for each such violation.

(302.1 added Nov. 9, 1965, P.L.671, No.329)

Section 303. By-laws; Seal.--(303 repealed Dec. 19, 1990, P.L.834, No.198)
Section 304. Annual Meeting of Stockholders or Members; Notice.--(304 repealed Dec. 19, 1990, P.L.834, No.198)

Section 305. Quorum of Members or Stockholders.--(305 repealed Dec. 19, 1990, P.L.834, No.198)

Section 306. Right to Vote Stock; Objections.--(306 repealed Dec. 19, 1990, P.L.834, No.198)

Section 307. Right to Vote as Between Pledgeor and Pledgee.--(307 repealed Dec. 19, 1990, P.L.834, No.198)

Section 308. Election of Directors and Trustees; Terms; Vacancies.--(First par. repealed Dec. 19, 1990, P.L.834, No.198) (Second par. repealed Dec. 19, 1990, P.L.834, No.198)

Any stockholder or member elected to the post of director or trustee shall continue in office unless the Insurance Commissioner, after such investigation as he deems proper, shall determine that the responsibility, character, and general fitness for the business, of such individual are not such as to command the confidence of the public, and to warrant the belief that the business of the company will be honestly and efficiently conducted in accordance with the intent and purpose of this act. Any adjudication by the Insurance Commissioner pursuant to this section shall be subject to the provisions of the "Administrative Agency Law," act of June 4, 1945 (P.L.1388). (308 amended Nov. 27, 1968, P.L.1118, No.349)

Section 309. Voting by Stockholders and Members; Proxies; Record of Votes.--(309 repealed Dec. 19, 1990, P.L.834, No.198)

Section 309.1. Proxies, Consents and Authorizations in Respect of Any Voting Security Issued by a Domestic Stock Insurance Company.--(a) The commissioner may, by regulation, prescribe the form, content and manner of solicitation of any proxy, consent or authorization in respect of any voting security issued by a domestic stock insurance company as necessary or appropriate in the public interest or for the proper protection of investors in the voting securities issued by such insurance company, or to insure the fair dealing in such voting securities.

(b) No person or voting security holder and no domestic stock insurance company or any director, officer or employe of such company shall solicit or permit the use of his name to solicit, by mail or otherwise, any person to give any proxy, consent or authorization in respect of any voting security issued by a domestic stock insurance company in contravention of any rule or regulation the commission may prescribe pursuant to this section.

(c) Any action to enforce compliance with any rule or regulation of the commissioner shall be taken within thirty (30) days after exercise of the proxy, consent or authorization and not thereafter.

(d) None of the provisions of this section shall apply to voting securities of a domestic stock insurance company if such voting securities shall be registered pursuant to section 12 of the Federal Securities Exchange Act of 1934, as amended. The provisions of this section shall also not apply to the voting securities of a domestic stock insurance company which, because of the number of its stockholders or the distribution of its stock ownership, the commissioner, by regulation, deems not necessary or appropriate to regulate in the public interest or for the proper protection of investors in the voting securities issued by such insurance company or to insure the fair dealing in such voting securities.

(e) The term "voting security" as used in this section shall mean any instrument which, in law or by contract, gives the
holder the right to vote, consent or authorize any corporate action of a domestic stock insurance company.

(309.1 added Nov. 9, 1965, P.L.675, No.330)


Section 311. Failure To Elect Directors or Trustees; Special Meeting.-- (311 repealed Dec. 19, 1990, P.L.834, No.198)

Section 312. Acceptance by Directors and Trustees; Powers; Quorum; Salaries.--(312 repealed Dec. 19, 1990, P.L.834, No.198)

Section 313. Stock Votes on Particular Subjects.--(313 repealed Dec. 19, 1990, P.L.834, No.198)

Section 314. Officers and Employes; Salaries; Vacancies.--(First par. repealed Dec. 19, 1990, P.L.834, No.198)

Any person chosen, either annually or to fill a vacancy, as president, secretary, treasurer, or for any other office, shall continue to serve in such office unless the Insurance Commissioner, after such investigation as he deems proper, shall determine that the responsibility, character, and general fitness for the business, of such individual are not such as to command the confidence of the public, and to warrant the belief that the business of the company will be honestly and efficiently conducted in accordance with the intent and purpose of this act. Any adjudication by the Insurance Commissioner pursuant to this section shall be subject to the provisions of the "Administrative Agency Law," act of June 4, 1945 (P.L.1388). (Second par. repealed in part Dec. 19, 1990, P.L.834, No.198) (314 amended Nov. 27, 1968, P.L.1118, No.349)

Section 315. Payment of Salaries of Employes in Military Service.--(315 repealed Dec. 19, 1990, P.L.834, No.198)

Section 316. Pensions.--(316 repealed Dec. 19, 1990, P.L.834, No.198)

Section 317. Execution of Insurance Policies.--Policies of insurance, made or entered into by any stock or mutual insurance company, may be made either with or without the seal thereof, and they shall be subscribed by the president, or such other officer as may be designated by the directors or trustees for that purpose, and shall be attested by the secretary or other designated officer, and, when so subscribed and attested, shall be obligatory on the company.

Section 317.1. Joint Policies.--Two or more insurance companies, associations or exchanges, authorized to transact the same kinds of insurance business in this Commonwealth, may issue a combination policy, using a distinctive title therefor, which title shall follow the titles of the several companies, associations or exchanges obligated thereby. Such policy shall be executed by each such company, association or exchange, in the same manner as it would execute its individual policy. Such policy shall state that it is a joint contract and that each company, association or exchange is only liable for a specific percentage of any loss or damage occurring thereunder. Before any such companies, associations or exchanges shall issue such combination policy, they shall receive the express permission of the Insurance Commissioner to issue the same and the title shall be approved by him. (317.1 added July 19, 1951, P.L.1100, No.245)

Section 318. Statement by Insured as Evidence.--No statement made by an insured shall be received in evidence in any controversy between the parties to, or a claimant or claimants interested in, a life insurance or health and accident insurance policy unless a copy of the document containing the statement is or has been furnished to such person or those legally acting on his behalf in the controversy.
Section 319. Reinsurance Regulated.--(a) No stock or mutual insurance company, association, or exchange, organized under the laws of this Commonwealth, shall reinsure its entire schedule of policies except by approval of the Insurance Commissioner.

(b) Any domestic or foreign stock or mutual insurance company, association, or exchange, authorized to transact business in this Commonwealth, may reinsure all or any part of its liability under one or more of its policy contracts with any stock or mutual insurance company, association, or exchange, doing the same or a similar kind of business, licensed to transact business in this Commonwealth or licensed to transact business in any of the United States, if such company, association, or exchange is and remains of the same standard of solvency and meets and continues to meet all other requirements fixed by the laws of this Commonwealth for companies, associations, or exchanges transacting the same classes of business within this Commonwealth. Any domestic or foreign stock or mutual insurance company, association, or exchange, authorized to transact business in this Commonwealth, shall pay to this Commonwealth taxes required on all business taxable within this Commonwealth and reinsured, as provided in this section, and may take credit for the reserves of each ceded risk to the extent reinsured subject to the exceptions provided in sections 319.1 through 319.2 inclusive.

Section 319.1. Reinsurance Credits.--(a) Unless an unlicensed reinsurer is qualified or certified to accept reinsurance from insurers licensed in this Commonwealth, no credit shall be allowed as an admitted asset or as a reduction of liability relative to risks ceded by such licensed insurers. Qualified or certified reinsurers are those meeting the conditions for reinsurers specified by the commissioner, in his discretion, and included on a list of qualified or certified reinsurers published and periodically reviewed by said commissioner.

(b) A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer in accordance with this section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer and such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution, as defined in subsection (g)(2). This security may be in the form of:

1. Cash.

2. Securities listed by a securities valuation office of a national association of insurance commissioners or any successor thereto, including those exempted from filing under the Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners, and qualifying as admitted assets.

3. (i) Clean, irrevocable, unconditional and evergreen letters of credit issued or confirmed by a qualified United States financial institution, as defined in subsection (g)(1), no later than the thirty-first day of December in respect of
the year for which filing is being made and in the possession of the ceding insurer on or before the filing date of its annual statement.

(ii) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

4 Funds or letters of credit provided by a noninsurer parent corporation of the ceding insurer, in lieu of the funds to be withheld by the ceding insurer under a reinsurance contract with such assuming insurer as security for payment of obligations thereunder, if the following requirements are met:

(i) The funds or letters of credit are held subject to withdrawal by and under the control of the ceding insurer.

(ii) The type, amount and form of the funds or letters of credit receive the prior approval of the Insurance Commissioner.

5 Any other form of security acceptable to the Insurance Commissioner.

(c) No credit shall be allowed as an admitted asset or as a deduction from liability, to any ceding company for reinsurance unless the reinsurance is payable to such company or its statutory liquidator by the assuming company on the basis of the liability of the ceding company under contract or contracts reinsured without diminution because of insolvency of the ceding company.

(d) No such credit shall be allowed for reinsurance unless the reinsurance agreement provides that payment by the company shall be made directly to the ceding company or to its liquidator, receiver, or statutory successor.

(e) No credit shall be allowed as an admitted asset or as a reduction in liability if the gross reserves established by the ceding insurer do not include provision for the policy benefits against which the ceding insurer is being indemnified by the reinsurer.

(f) Notwithstanding the provisions of this section, the Insurance Department may promulgate one or more regulations to limit, prohibit or authorize the credit which a domestic insurer may take as an admitted asset or as a reduction in liability with respect to reinsurance ceded on any financial statements filed with the Insurance Department.

(f.1) Credit for reinsurance ceded to a certified reinsurer is allowed only for reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer by the Insurance Commissioner.

(g) (1) The term "qualified United States financial institution" when used in this section means an institution which meets the following qualifications:

(i) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof.

(ii) Is regulated, supervised and examined by United States Federal or state authorities having regulatory authority over banks and trust companies.

(iii) Has been determined by either the Insurance Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners or a successor thereto to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality
of financial institutions whose letters of credit will be acceptable to the Insurance Commissioner.

(2) The term "qualified United States financial institution" also means, for the purposes of the provisions of this act specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that meets the following qualifications:

(i) Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers.

(ii) Is regulated, supervised and examined by Federal or state authorities having regulatory authority over banks and trust companies.

(319.1 amended June 5, 2012, P.L.1111, No.136)

Section 319.2. Exemption for Reinsurance Among Certain Affiliates.--(a) As used in this section the terms "affiliated" and "affiliate" shall have the same meaning as set forth in section 337.7, providing however, that control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with power to vote, or holds shares representing eighty per centum (80%) or more of the voting power of any other person.

(b) Nothing contained in sections 319 or 319.1 shall apply to reinsurance agreements between or among affiliates covering all or substantially all of one or more lines of insurance of an affiliated domestic or foreign stock or mutual insurance company, association or exchange, provided that the amount of net written premium retained and the amount of the reinsurance and retrocession assumed by any affiliate participating agreement shall not be unreasonably large in relationship to its policyholders' surplus.

(319.2 added Dec. 3, 1975, P.L.474, No.139)

Section 320. Annual and Other Reports; Penalties.--(a) (1) Every stock and mutual insurance company, association, and exchange, doing business in this Commonwealth, shall annually, on or before the first day of March, file in the office of the Insurance Commissioner and with the National Association of Insurance Commissioners a statement which shall exhibit its financial condition on the thirty-first day of December of the previous year, and its business of that year and shall, within thirty days after requested by the Insurance Commissioner, file with the Insurance Commissioner and with the National Association of Insurance Commissioners such additional statement or statements concerning its affairs and financial condition as the Insurance Commissioner may, in his discretion, require. The Insurance Commissioner shall require each insurance company association and exchange to report its financial condition on the statement convention blanks, in such form as adopted by the National Association of Insurance Commissioners and shall, upon written request, furnish such blanks for their convenience; and may make such changes, from time to time, in the form of the same as shall seem best adapted to elicit from them a true exhibit of their financial condition.

(2) Unless otherwise provided by law, regulation or order of the Insurance Commissioner, each insurance company, association and exchange shall adhere to the annual or quarterly statement instructions and the accounting practices and procedures manuals prescribed by the National Association of Insurance Commissioners. The Insurance Commissioner may require each insurance company, association and exchange to file in the office of the Insurance Commissioner and with the National
Association of Insurance Commissioners financial statements on
diskettes or other electronic information storage devices
acceptable to the Insurance Commissioner.

(b) Insurance companies of foreign governments, doing
business in this Commonwealth, shall be required to return only
the business done in the United States, and the assets held by
and for them within the United States for the protection of
policyholders therein.

(c) In the absence of actual malice, members of the National
Association of Insurance Commissioners, their duly authorized
committees, subcommittees and task forces, their delegates and
employees and all others charged with the responsibility of
collecting, reviewing, analyzing and disseminating the
information developed from the filing of the annual statement
convention blanks shall be acting as agents of the Insurance
Commissioner under the authority of this act and shall not be
subject to civil liability for libel, slander or any other cause
of action by virtue of their collection, review and analysis
or dissemination of the data and information collected from the
filings required hereunder.

(d) (1) The following documents, materials or information
shall be confidential by law and privileged and shall not be
subject to subpoena, discovery, the act of February 14, 2008
(P.L.6, No.3), known as the "Right-to-Know Law," or admissible
in evidence in any private civil action:

(i) All documents, materials or other information prepared
or provided by an insurance company, association or exchange
solely in support of the statement of actuarial opinion filed
under this section, including actuarial reports, work papers
or actuarial opinion summaries and any other material solely
prepared by the insurance company, association or exchange for
the purpose of providing it to the Insurance Department in
connection with actuarial reports, work papers or actuarial
opinion summaries.

(ii) All financial analysis ratios, analyst team reports
and other financial analytical results concerning insurance
companies, associations and exchanges that are provided to the
Insurance Department by the National Association of Insurance
Commissioners.

(iii) All additional work products, documents, materials
or information produced by, obtained by or provided to the
Insurance Department in the course of conducting financial
analyses of financial statements filed under this section.

(2) The protections established under paragraph (1)(i) and
(iii) shall also apply to the materials, drafts or copies
thereof when in possession of the insurance company, association
or exchange if the materials or drafts were prepared solely for
the purpose of submitting the materials to the Insurance
Department. Any documents, materials or information that are
provided to the Insurance Department under paragraph (1)(i) or
(iii) and that would otherwise be available from original
sources shall not be construed as immune from discovery from
the original source and use in any private civil action merely
because they were provided to the Insurance Department.

(3) Neither the Insurance Commissioner nor any individual
or person who receives documents, materials or information while
acting under the authority of the Insurance Commissioner shall
be permitted or required to testify in any private civil action
concerning any confidential documents, materials or information
covered under this section.

(4) No waiver of any applicable privilege or claim of
confidentiality in the documents, materials or information shall
occur as a result of disclosure to the Insurance Commissioner or as a result of the Insurance Commissioner sharing information in conformance with sections 201-A and 202-A of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."

(5) The Insurance Commissioner may use the documents, materials or other information obtained or created under this section in furtherance of any regulatory or legal action brought as part of the Insurance Commissioner's official duties.

(e) (1) Any company, association, or exchange, which neglects to make and file its annual statement, or other statements that may be required, in the form or within the time herein provided shall forfeit a sum not to exceed two hundred dollars ($200) for each day during which such neglect continues, and, upon notice by the commissioner, its authority to do new business shall cease while such default continues.

(2) For wilfully making a false annual or other statement required by law, an insurance company, association or exchange, and the persons making oath to or subscribing the same, shall severally be punished by a fine of not less than one thousand dollars ($1,000) nor more than ten thousand dollars ($10,000). A person who wilfully makes oath to such false statement shall be guilty of perjury.

(3) The Insurance Commissioner may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due.


Section 320.1. Admitted Assets.--(320.1 repealed July 10, 2002, P.L.749, No.110)

Section 321. Additional Annual Reports from Foreign Companies and Associations.--Every stock or mutual insurance company, association, or exchange of another State or foreign government, authorized to do business in this Commonwealth, shall make report to the Department of Revenue, on or before March fifteenth of each year, under oath of its president, secretary, or attorney, showing the gross premiums of every character and description received from business transacted in the Commonwealth during the year, or fraction of year, ending with the thirty-first day of December preceding, whether said premiums were received in money or in the form of notes, credits, or any other substitute for money or whether the same were collected in this Commonwealth or elsewhere, and to pay to the State Treasury the requisite tax upon all such premiums. Such companies, associations, and exchanges, in making such report, may deduct, from the gross premiums received, all premiums returned on policies canceled or not taken, and all premiums actually received for reinsurances. Stock companies with participating features, in addition to the aforesaid deductions, may deduct that portion of the premiums returned to the policyholders. Life insurance companies may deduct dividends declared and actually used by policyholders in payment of renewal premiums; and mutual companies, associations, and exchanges may deduct that proportion of the advance premium or deposit returned to members upon the expiration of termination of their contracts. "Gross premiums" are defined to be the amount of dues, fees, and premiums stated in the policy contracts.

(321 amended July 10, 1951, P.L.1100, No.245)

Section 322. Amendment of Charter.--(a) ((a) repealed Dec. 19, 1990, P.L.834, No.198)

(b) ((b) repealed Dec. 19, 1990, P.L.834, No.198)

(c) ((c) repealed Dec. 19, 1990, P.L.834, No.198)
(d) A mutual insurance company, other than life or title, shall be permitted to amend its charter to include any or all of the kinds of insurance included in section 202, subdivisions (b) and (c), if its total assets less net liability for losses, for expenses and for unearned premium reserve are not less than the minimum surplus specified in section 206 (e) for the incorporation of new companies, without the necessity of obtaining or of holding any application or of issuing any policy as specified in section 206 (e) for the incorporation of new companies. ((d) amended Dec. 18, 1992, P.L.1519, No.178)

(e) Before any domestic stock fire, stock marine, stock fire and marine, or stock casualty insurance company transacting business under subdivisions (b) or (c) of section two hundred two of this act may procure an amendment to its charter for the transaction of additional kinds or classes of business under subdivisions (b) or (c) or both, said section two hundred two, it must have a paid up capital and a paid in or accumulated surplus in amounts required by subdivisions (b) or (c) or both, section two hundred six of this act, for incorporation for its present and proposed additional purposes.


Section 322.1. Contributions to Surplus.--(322.1 repealed Nov. 30, 2004, P.L.1690, No.216)

Section 322.2. Surplus Notes.--(a) A director, officer, person, corporation or other entity may advance cash, or other admitted assets having readily determinable values and liquidity satisfactory to the Insurance Commissioner, to a domestic insurer in exchange for a surplus note only as prescribed under this section. In addition, if a director, officer, person, corporation or other entity would acquire control of an insurer as a result of an advance, as control is defined in Article XIV, the advance may be made only after the director, officer, person, corporation or other entity has complied with the requirements relating to filing and approval of acquisitions of control prescribed under Article XIV.

(b) An advance may not be made unless the insurer has provided the Insurance Commissioner with written notice at least thirty days prior to the intended date of the advance, or such shorter period as the Insurance Commissioner may permit, and the Insurance Commissioner has not disapproved the advance prior to the intended date. The written notice shall include the form and amount of the advance, the content of the surplus note and other information relating to the advance as required by the Insurance Commissioner.

(c) Commissions, promotion expenses or finders fees may not be paid in connection with an advance except for commissions, expenses and fees customarily incurred within the context of public or private placement offerings underwritten by an investment banking or similar entity.

(d) Payment of principal or interest on a surplus note may not be made without the prior written approval of the Insurance Commissioner. The insurer shall provide the Insurance Commissioner with written notice at least thirty days prior to the intended date of the payment of principal or interest on a surplus note or such shorter period as the Insurance Commissioner may permit.

(e) Payment of principal or interest on a surplus note shall be subordinated to payment of all other liabilities of the insurer.

(f) Payment of interest on a surplus note may be made only from the unassigned funds of the insurer.
(g) An insurer shall report the issuance and holding of surplus notes, including principal repayment and interest, in financial statements filed with the Insurance Commissioner in compliance with statutory accounting practices prescribed or otherwise permitted by the Insurance Commissioner. Statutory accounting practices are the practices and procedures prescribed by the Accounting Practices and Procedures Manual published by the National Association of Insurance Commissioners, or successor organization, or as otherwise provided by law, regulation or order of the Insurance Commissioner. Principal or interest on a surplus note may not be recorded as a liability or an expense against the insurer except to the extent that payment has been approved by the Insurance Commissioner.

(h) The term "insurer" when used in this section shall mean a domestic insurance company, association or exchange; reciprocal or interinsurance exchange; employers' mutual liability insurance association; nonprofit health plan corporation, whether operating a hospital plan or a professional health services plan; fraternal benefit society or beneficial association; health maintenance organization; preferred provider organization; the Industry Placement Facility under the act of July 31, 1968 (P.L.738, No.233), known as "The Pennsylvania Fair Plan Act"; a joint underwriting association under Chapter 7 of the act of March 20, 2002 (P.L.154, No.13), known as the "Medical Care Availability and Reduction of Error (Mcare) Act"; or another person, corporation, company, partnership, association or other entity acting as an insurer.

(322.2 added Nov. 30, 2004, P.L.1690, No.216)

Section 323. Power To Increase Capital Stock.--(323 repealed Dec. 19, 1990, P.L.834, No.198)


Section 325. Records of Increase of Capital Stock Filed with Secretary of Commonwealth; Bonus.--(325 repealed Dec. 19, 1990, P.L.834, No.198)

Section 326. Sale of Increases of Capital Stock; Issuance to Officers or Employes.--(326 repealed Dec. 19, 1990, P.L.834, No.198)

Section 327. Power To Reduce Capital Stock.--(327 repealed Dec. 19, 1990, P.L.834, No.198)

Section 328. Meeting of Stockholders for Reduction of Capital Stock; Notice.--(328 repealed Dec. 19, 1990, P.L.834, No.198)


Section 330. Stock Entitled To Vote on Reduction of Capital Stock.--(330 repealed Dec. 19, 1990, P.L.834, No.198)

Section 331. Filing, Approval, and Recording of Proceedings To Reduce Capital Stock.--(331 repealed Dec. 19, 1990, P.L.834, No.198)

Section 332. Power to Merge or Consolidate.-- (332 repealed Dec. 19, 1990, P.L.834, No.198)

Section 333. Proceedings To Merge or Consolidate.--(333 repealed Dec. 19, 1990, P.L.834, No.198)

Section 334. Filing, Approval, and Recording of Certificates and Agreement for Merger or Consolidation; Letters Patent.--(334 repealed Dec. 19, 1990, P.L.834, No.198)

Section 335. Certified Copies of Proceedings To Merge or Consolidate To Be Evidence.--(335 repealed Dec. 19, 1990, P.L.834, No.198)

Section 336. Ascertainment of Value of Stock or Interest of Dissatisfied Stockholders and Members in Merger or

Section 337. Merger of Domestic and Foreign Life Fire and Marine Insurance Companies and/or Casualty and/or Surety Companies.--(337 repealed Dec. 19, 1990, P.L.834, No.198)

Section 337.1. Any domestic insurance company may retain or acquire the whole or any part of the capital stock of other insurance companies, provided no insurance company shall, by reason of such retention or acquisition of such capital stock, conduct its business with the public in a manner which substantially lessens competition or tends to create a monopoly, and provided, further, such retention or acquisition is consistent with the provisions of the law relating to the investment of the funds of domestic insurance companies.

(337.1 added June 5, 1947, P.L.443, No.201)

Section 337.2. Any person otherwise qualified may be a director of two or more insurance companies when such interlocking directorate is not used as a means of substantially lessening competition or tending to create a monopoly.

(337.2 added June 5, 1947, P.L.443, No.201)

Section 337.3. Whenever the Insurance Commissioner has reason to believe that there is a violation of section three hundred thirty-seven, point one or section three hundred thirty-seven, point two of this act, he shall serve upon the insurance company, or the director concerned, a complaint setting forth the facts alleged to constitute such violation, with which complaint there shall be given a notice in writing of a time and place of a hearing before the Insurance Commissioner, to be held not less than thirty days after the service of such complaint, and requiring such insurance company or director to show cause why an order should not be made by the Insurance Commissioner directing such insurance company or director to cease and desist from such violation.


Section 337.4. Nothing contained in the foregoing three sections shall authorize any order, judgment or decree directing any domestic insurance company to divest itself of the capital stock of another insurance company.

(337.4 added June 5, 1947, P.L.443, No.201)

Section 337.5. Acquisition of Stock by Business Corporations.--(337.5 repealed Dec. 19, 1990, P.L.834, No.198)

Section 337.6. Approval of the Insurance Commissioner Required in Connection with Certain Acquisitions of or Offers to Acquire the Capital Stock of Certain Corporations.--(337.6 repealed Dec. 18, 1992, P.L.1519, No.178)
Section 337.7. Insurance Companies Which Are Members of an Insurance Holding Company System Required to Register with Insurance Commissioner; Approval of Insurance Commissioner Required in Connection with Certain Transactions Between Insurance Companies and Insurance Holding Company Systems.--(337.7 repealed Dec. 18, 1992, P.L.1519, No.178)

Section 337.8. Disposition of Unassigned Funds.--(a) Any domestic insurance company, association or exchange may pay dividends and other distributions to its shareholders only out of unassigned funds (surplus) or upon approval of the Insurance Commissioner as set forth in subsection (b).

(b) A domestic insurance company, association or exchange may, conditioned upon receipt of the Insurance Commissioner's approval, declare a dividend or other distribution from other than unassigned surplus, provided, however, that the declaration shall confer no rights upon the security holders of the insurer, and the insurer may not pay the dividend until the Insurance Commissioner has:

(1) Approved the payment of the dividend or other distribution.

(2) Not disapproved the payment of the dividend or other distribution within thirty days after receipt of written notice from the insurer of the declaration thereof. The written notice shall include a schedule setting forth all dividends or other distributions made within the previous twelve months.

(c) Notwithstanding subsection (b), no dividend or other distribution may be declared or paid by a domestic insurance company, association or exchange which would reduce its total capital and surplus to an amount which is less than the amount required by the Insurance Department for the kind or kinds of business which it is authorized to transact.

(d) All information reported to the Insurance Commissioner pursuant to this section shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the Insurance Commissioner or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the Insurance Commissioner, after giving the insurer and any affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event he may publish all or any part thereof in such manner as he may deem appropriate.

(e) As used in this section, "unassigned funds (surplus)" means undistributed, accumulated surplus, including net income and unrealized gains, since the organization of the insurer.

(337.8 added Feb. 17, 1994, P.L.92, No.9)


Section 339. Failure To Do Business; Dissolution.--If any stock or mutual insurance company does not commence to issue policies within one year from the date of its letters patent, or if any insurance company shall cease for one year to make new insurances, its corporate powers and existence shall cease, and the court, upon petition of the Attorney General, may fix by decree the time within which it shall settle and close its affairs.

(339 amended Apr. 17, 1968, P.L.94, No.43)

Section 340. Foreign Insurance Companies, Et Cetera; Authorized To Hold Real Estate.--(340 repealed Dec. 19, 1990, P.L.834, No.198)

Section 342. Real Estate of Foreign Insurance Companies Subject to taxation.--Nothing herein contained shall be deemed to prevent or relieve real estate, acquired, held, mortgaged, leased, or conveyed, by any insurance company, under the provisions of this act, from being taxed in the same manner as other real estate within this Commonwealth is taxed.
(342 amended July 15, 1935, P.L.1019, No.335)

Section 343. Validation of Titles Held by Foreign Insurance Companies, Etc.--(343 repealed Dec. 19, 1990, P.L.834, No.198)

Section 344. Actions by and against Insurance Companies.--(344 repealed Dec. 19, 1990, P.L.834, No.198)

Section 345. Embezzlement by Officers, Agents, Etc.--If any director, officer, agent, or other person connected with, or doing business for or with, any insurance company, association, or exchange, incorporated or organized under the laws of the State of Pennsylvania or any other State of the United States or any foreign government, which has complied with the insurance laws of this Commonwealth, shall fraudulently embezzle or appropriate to his use or the use of any other person or persons any money or other property belonging to such company, association, or exchange, or left with or held by such company, association, or exchange in trust, he or they, on conviction thereof, shall be fined in the amount so appropriated or embezzled, or be sentenced to undergo an imprisonment in the penitentiary for a term not exceeding five (5) years, or by both such fine and imprisonment. In the indictment and trial of any case under this section, it shall not be necessary, in order to establish a prima facie case for the Commonwealth, to set forth or prove the incorporation of any such company, except by the verbal testimony of any competent witness.

Section 346. Rebates and Inducements Prohibited; Revocation of Licenses; Penalties.--(a) Except as otherwise provided in this section, no insurance company, association, or exchange, by itself or by its officers or members, attorney-in-fact or by any other party, shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of, or part of, the premium payable on the policy, or on any policy or agent's commission thereon, or earnings, profit, dividends, or other benefit founded, arising, accruing, or to accrue thereon or therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind, or any other valuable consideration or inducement, to or for insurance on any risk in this Commonwealth, now or hereafter to be written, which is not specified in the policy contract of insurance; nor shall any such company, association, or exchange, personally or otherwise, offer, promise, give, option, sell, or purchase any stocks, bonds, securities, or property, or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever, as inducement to insurance or in connection therewith, which is not specified in the policy. Nothing in this section shall be construed to prevent the taking of a bona fide obligation, with legal interest, in payment of any premium.

(b) An insurance company, association or exchange, by itself, its officers, members or attorney-in-fact or any other party may offer or give to an insured or a prospective insured, on an annual aggregate basis, any favor, advantage, object, valuable consideration or anything other than money that has a
cost or redeemable value of less than or equal to one hundred dollars ($100). The Insurance Commissioner may increase this amount upon publication of notice in the Pennsylvania Bulletin.

(b.1) Notwithstanding any other provision of this section to the contrary, an insurance company, association or exchange, by itself, its officers, members or attorney-in-fact or any other party may not make receipt of anything of value contingent on the purchase of insurance.

(c) Nothing in this section shall be construed as:

(1) preventing a company transacting industrial life insurance on a weekly payment plan from returning to policyholders, who have made a premium payment for a period of at least one year, the percentage of premium which the company would otherwise have paid for the weekly collection of such premium;

(2) permitting any unfair method of competition or an unfair or deceptive act or practice under the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act"; or

(3) prohibiting an insurance company, association or exchange, by itself or by its officers or members, attorney-in-fact or by any other party from offering or giving to an insured or a prospective insured, for free or at a discounted price, services or other offerings that relate to loss control of the risks covered under the policy.

(346 amended May 4, 2018, P.L.116, No.23)

Section 347. Misrepresentations of Terms of Policy and Future dividends by Companies, Et Cetera.--No insurance company, association, or exchange, or any member, officer, director, or attorney-in-fact thereof, or any other person in its behalf, shall issue, circulate, or use, or cause or permit to be issued, circulated, or used, any written or oral statement or circular misrepresenting the terms of any policy issued or to be issued by such company, association, or exchange, or make an estimate, with intent to deceive, of the future dividends payable under any such policy.

Section 348. Misrepresentations, Et Cetera; for Purpose of Inducing Policyholders To Drop Present Policies and Insure with Other Companies, Et Cetera.--No insurance company, association, or exchange, and no member, officer, director, or attorney-in-fact thereof, or any other person in its behalf, shall make any misrepresentation or incomplete comparison of policies, oral, written, or otherwise, to any person insured in any company, association, or exchange, for the purpose of inducing or tending to induce a policyholder in any company, association, or exchange to lapse, forfeit, or surrender his insurance therein, and to take out a policy of insurance in another company, association, or exchange insuring against similar risks.

Section 349. Fraud in Procuring Insurance or in Collecting Claims.--(a) Any person who is knowingly concerned in, or who, for profit, gain, benefit, favor, or otherwise, makes any false oral statement, misrepresents, substitutes persons or realty or goods, subscribes to or prepares, or helps to prepare, any fraudulent letter, document, application, affidavit, inventory, financial or other statement, or in any method or manner attempts to deceive, for the purpose of obtaining for himself, herself, or others, any of the classes of insurance provided for by this act; and (b) any person knowingly concerned for profit, gain, benefit, favor, or otherwise, in preparing or forwarding any fraudulent application, affidavit, proof of loss, or claim, or attempting to collect or collecting any wholly or
partly fraudulent claim or money demand from any insurance company, association, or exchange, lawfully transacting business within this Commonwealth, whether any policy or agreement of insurance was lawfully procured or procured by fraud, shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to undergo imprisonment for not more than one year or less than six months, and, in addition, to pay a fine not exceeding five hundred dollars ($500) or less than one hundred dollars ($100). The provisions of this section shall apply whether or not insurance was actually in force and whether or not the offending person or persons received profit, gain, benefit, or favor from the attempt to defraud or from the consummation of the fraud.

Section 349.1. Immunity from Liability.--(a) In the absence of fraud or bad faith, no person or his employes or agents shall be subject to civil liability and no civil cause of action shall arise against any of them for any of the following:

(1) Information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished by them to or received from Federal, State or local law enforcement officials, their agents and employes and designees.

(2) Information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished by them to or received from other persons subject to the provisions of this act.

(3) Information furnished by them or received from a Federal, State or local agency, the National Association of Insurance Commissioners or another organization established to detect and prevent fraudulent insurance acts, their agents, employes or designees or a recognized comprehensive database system approved by the Insurance Department.

(a.1) In the absence of fraud or bad faith, the immunity granted in subsection (a) shall also apply to persons identified as designated employes of insurers, self-insurers or insurance licensees whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent insurance acts when sharing information on such acts or persons suspected of engaging in such acts with other designated employes of the same or other insurers, self-insurers or insurance licensees whose responsibilities include the investigation or disposition of claims relating to suspected fraudulent insurance acts.

(b) State agencies and their employes and designees, in the absence of fraud or bad faith, shall not be subject to civil liability for sharing information identified in subsection (a). No civil cause of action shall arise against any of them by virtue of the publication of a report or bulletin related to the official activities of the State agency.

(c) Nothing in this section is intended to abrogate or modify a common law or statutory immunity heretofore enjoyed by any person.

(d) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Absence of bad faith" means without serious doubt that the information furnished or received, or the report or bulletin published, is not true.

"Absence of fraud" means without knowledge that the information furnished or received, or the report or bulletin published, is not true.

"Fraudulent insurance act" means an act committed by a person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or broker,
or an agent of an insurer, purported insurer or broker, information as part or in support of an application for the issuance or rating of an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning a fact material to the statement or claim or to conceal, for the purpose of misleading, information concerning a fact material to the statement or claim.

"Insurer" means an insurance company, association, exchange, interinsurance exchange, health maintenance organization, preferred provider organization, professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), fraternal benefit society, beneficial association, Lloyd's insurer or health plan corporation.

(349.1 amended Oct. 27, 2010, P.L.952, No.97)

Section 350. Revocation, Et Cetera, of Certificates of Authority; Penalty.--Upon satisfactory evidence of the violation of any of sections three hundred forty-six (346), three hundred forty-seven (347), three hundred forty-eight (348), or three hundred forty-nine (349) of this act by any insurance company, association, or exchange, its members, officers, directors, or attorney-in-fact, the Insurance Commissioner may, in his discretion, take, against the offending party or parties, any one or more of the following courses of action: (1) Revoke the certificate of authority of such offending company, association, or exchange; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such offending company, association, or exchange; (3) impose a penalty of not more than one thousand dollars for each act of violation of said sections.

Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of such alleged violation and fixing a time and place, at least ten (10) days thereafter, when a hearing of the matter shall be held. After such hearing or upon failure of the accused to appear at such hearing, the Insurance Commissioner shall impose such of the above penalties as he deems advisable. Any insurance company, or the officers, directors, members, or attorney-in-fact of any insurance company, association, or exchange, or any other person, violating the provisions of any of the aforesaid sections, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than five hundred dollars ($500.00) for each and every violation, or to imprisonment in the jail of the county in which the offense is committed for a period of not more than six (6) months, or both. (Par. repealed in part Apr. 28, 1978, P.L.202, No.53)

(350 amended June 23, 1931, P.L.904, No.301)

Section 351. Testimony; Production of Books, Et Cetera.--No person shall be excused from testifying or from producing any books, papers, contracts, agreements, or documents at any hearing held by the Insurance Commissioner, or at the trial or hearing before any magistrate, justice of the peace or judge, of any person or company charged with violating any of the provisions of sections three hundred and forty-six (346), three hundred and forty-seven (347), three hundred and forty-eight (348), and three hundred and forty-nine (349) of this act, on the ground that such testimony or evidence may tend to
incriminate himself, but no person shall be prosecuted for any act concerning which he shall be compelled so to testify or produce evidence, documentary or otherwise, except for perjury committed in so testifying.

(351 amended June 23, 1931, P.L.904, No.301)

Compiler's Note: Section 28 of Act 207 of 2004 provided that any and all references in any other law to a "district justice" or "justice of the peace" shall be deemed to be references to a magisterial district judge.


Section 353. Unfair Discrimination Prohibited.--Unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, and any other lines and kinds of insurance not within the scope of The Fire Marine and Inland Marine Regulatory Act and The Casualty and Surety Rate Regulatory Act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited.

Any person, corporation, insurance company, association, or exchange that shall, either as principal or agent, issue, or cause to be issued, any policy or contract of insurance within this Commonwealth, contrary to this section, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding five hundred dollars ($500.00).

Upon satisfactory evidence of the violation of this section by any such person, corporation, insurance company, association, or exchange, the Insurance Commissioner may, in his discretion, pursue any one or more of the following courses of action: (1) Suspend or revoke the license of such offending person, corporation, insurance company, association, or exchange; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such person, corporation, insurance company, association, or exchange; (3) impose a penalty of not more than five hundred ($500) dollars for each and every act in violation of this act.


Section 354. Approval of Policies, Contracts, etc.; Prohibiting the Use Thereof Unless Approved; Judicial Review; Penalty.--It shall be unlawful for any insurance company, association, or exchange, including domestic mutual fire insurance companies, doing business in this Commonwealth, to issue, sell, or dispose of any policy, contract, or certificate, covering life, health, accident, personal liability, fire, marine, title, and all forms of casualty insurance, or contracts pertaining to pure endowments or annuities, or any other contracts of insurance, or use applications, riders, or endorsements, in connection therewith, until the forms of the same have been submitted to and formally approved by the Insurance Commissioner, and copies filed in the Insurance Department, except riders and endorsements relating to the manner of distribution of benefits, and to the reservation of rights and benefits under any such policy, and except any forms which, in the opinion of the Insurance Commissioner, do not require his approval.
Forms so filed, forms filed under the act, approved the eleventh day of May, one thousand nine hundred forty-nine (Pamphlet Laws 1210), or any amendments thereof, or filed under any other section of this law, shall be deemed approved at the expiration of thirty (30) days after filing, unless earlier approved or disapproved by the Insurance Commissioner. The Insurance Commissioner, by written notice to the insurer may, within such thirty-day period, extend the period for approval or disapproval for an additional thirty (30) days.

Such approval shall become void upon any subsequent notice of disapproval from the Insurance Commissioner, or upon any subsequent withdrawal of license of refusal of the Insurance Commissioner to relicense any such company, association, or exchange, or upon the subsequent passage of an act which would no longer make such contracts or related forms a fit subject for approval, except that this provision shall not affect contracts issued prior thereto.

Upon any disapproval, the Insurance Commissioner shall notify the insurer in writing, specifying the reason for such disapproval; and within thirty (30) days from the date of mailing of such notice to the insurer, such insurer may make written application to the Insurance Commissioner for a hearing thereon, and such hearing shall be held within thirty (30) days after receipt of such application. The procedure before the Insurance Commissioner shall be in accordance with the adjudication procedure set forth in the "Administrative Agency Law," and the insurer shall be entitled to the judicial review as provided for in said law.

Any person, corporation, insurance company, exchange, order, or society that shall, either as principal or agent, issue, or cause to be issued, any policy or contract of insurance within the Commonwealth, contrary to this section, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding five hundred dollars ($500.00).

Upon satisfactory evidence of the violation of this section by any such person, corporation, insurance company, exchange, order, or society, the Insurance Commissioner may, in his discretion, pursue any one or more of the following courses of action: (1) Suspend or revoke the license of such offending person, corporation, insurance company, exchange, order or society; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such person, corporation, insurance company, exchange, order, or society; (3) impose a fine of not more than one thousand dollars ($1,000.00) for each and every act in violation of this act. (Par. repealed in part Apr. 28, 1978, P.L.202, No.53)


Compiler's Note: Section 14(b) of Act 159 of 1996 provided that section 354 is repealed insofar as it provides for the approval of accident and health forms.

Section 354.1. Out-of-State Coverage.--(a) No insurer shall issue in this Commonwealth group property and casualty insurance coverage provided under a group policy issued in another state or deliver or issue for delivery in this Commonwealth a certificate of group property and casualty insurance evidencing coverage under a group policy issued in another state unless such coverage is in compliance with the requirements of this act or any other applicable act.

(b) (1) For group property and casualty insurance coverage provided in this Commonwealth under a policy issued in another state, all group policies, certificates, amendments, endorsements and enrollment forms shall be filed with the
Insurance Commissioner for approval. The insurer shall also file with the Insurance Commissioner evidence of approval in the state where the group policy is issued.

(2) Forms so filed for approval shall be subject to the provisions of section 354.

(354.1 added Feb. 17, 1994, P.L.92, No.9)

Section 354.2. Notice of Compensation.--(a) In the case of a policy issued to an association on a group basis, if compensation of any kind will or may be paid to a policyholder or a sponsoring or endorsing entity, the insurer shall cause to be distributed to prospective insureds, in a written notice, that compensation will or may be paid.

(b) Such notice shall be distributed:

(1) Whether compensation is direct or indirect; and

(2) Whether such compensation is paid to or retained by the policyholder or sponsoring or endorsing entity or paid to or retained by a third party at the direction of the policyholder or a sponsoring or endorsing entity or any entity affiliated therewith by way of ownership, contract or employment.

(c) The notice required by this section shall be placed on or accompany any application or enrollment form provided to prospective insureds.

(d) For purposes of this section, a "sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with such organization or that it encourages participation in the program.

(354.2 added Feb. 17, 1994, P.L.92, No.9)

Section 354.3. Existing Policy and Existing Certificate.--The provisions of sections 354.1 and 354.2 shall not invalidate or otherwise affect any group policy legally issued prior to the effective date of this section or certificate in effect prior to the effective date of this section. All such group policies or certificates may remain in full force and effect until renewed, notwithstanding the fact that they do not comply with the provisions of this act.

(354.3 added Feb. 17, 1994, P.L.92, No.9)

Section 354.4. Newly Issued Group Policy.--Any group policy issued on or after the effective date this section is enacted shall comply with the provisions of this act.

(354.4 added Feb. 17, 1994, P.L.92, No.9)

Section 354.5. Newly Issued Certificate.--Any certificate issued on or after the effective date of this section under a group policy issued prior to the effective date of this section or certificate issued under a group policy issued on or after the effective date of this section shall comply with the provisions of this act.

(354.5 added Feb. 17, 1994, P.L.92, No.9)

Section 354.6. Minimum Number of Covered Employes.--Any policy of group life insurance issued pursuant to section 2 of the act of May 11, 1949 (P.L.1210, No.367), referred to as the Group Life Insurance Policy Law, and any policy of group accident and health insurance issued pursuant to section 621.2 shall cover at least two or more employes at the date of issue.

(354.6 added July 9, 2010, P.L.362, No.51)

Section 354.7. Electronic Delivery of Information and Posting of Policies and Endorsements.--(a) (1) With regard to any law or regulation of this Commonwealth requiring an insurer to provide, send or deliver information, notices or documents in writing to an insured or applicant as part of an insurance transaction if the insurer and the insured or
applicant agree to conduct a transaction by electronic means, the requirement is satisfied if the information is provided, sent or delivered, as the case may be, in an electronic record capable of retention by the recipient at the time of receipt. An electronic record is not capable of retention by the recipient if the sender or its information processing system inhibits the ability of the recipient to print or store the electronic record. The provisions of the act of December 16, 1999 (P.L.971, No.69), known as the "Electronic Transactions Act," shall otherwise apply to the insurer and the insured or applicant with respect to the providing, sending or delivering of the information, notices or documents.

(2) Any law or regulation requiring an insurer to send multiple copies of the information, notices or documents shall not apply where the insurer provides, sends or delivers the information, notices or documents in accordance with the provisions of the "Electronic Transactions Act."

(3) An insurer providing, sending or delivering information, notices or documents shall satisfy any font, size, spacing or other format requirements if the electronic information, notices or documents as provided, sent or delivered by the insurer meet those requirements and may be printed or saved by the insured or applicant using programs or applications widely available on the Internet and free of charge to use.

(b) Notwithstanding subsection (a) or any other law or regulation of this Commonwealth requiring an insurer to provide, send or deliver an insurance policy or endorsement to an insured, an insurer may elect to post a policy or endorsement that does not contain personally identifiable information on its Internet website provided it complies with all of the following:

(1) The policy or endorsement is easily accessible on the Internet website so long as it is in force.

(2) The policy or endorsement is posted in a manner that enables the insured to print and save it using programs or applications widely available on the Internet and free of charge to use.

(3) The insurer provides notice, in the manner it normally communicates with the insured, at the time of issuance or renewal of the policy or endorsement, or at the time of any changes to the policy or endorsement, of a method by which the insured may obtain, upon request and without charge, a paper or electronic copy of the policy or endorsement, or any changes to them, and the Internet address where the policy and endorsement are posted.

(4) The insurer provides all of the following information on each declarations page, or similar document as appropriate to the line of coverage, provided to the insured at the time of issuance or renewal:

(i) A description of the exact policy and endorsement forms purchased by the insured.

(ii) A method by which the insured may obtain, upon request and without charge, a paper or electronic copy of the policy or endorsement, or any changes to them.

(iii) The Internet address where the policy and endorsement are posted.

(5) After expiration of the policy or endorsement, the insurer archives the expired policies or endorsements in accordance with the Insurance Department's general record retention requirements and makes them available upon request.

(c) Upon satisfactory evidence of the violation of this section by an insurer, the Insurance Commissioner may, in his
discretion, pursue one or more of the following courses of action:

(1) Suspend or revoke the license of the insurer.
(2) Refuse, for a period not to exceed one year thereafter, to issue a new license to the insurer.
(3) Impose a fine of not more than one thousand dollars ($1,000) for each act in violation of this section.

(354.7 added Oct. 25, 2013, P.L.656, No.78)

Section 355. Companies Authorized to Apply for and Obtain Insurance of Mortgages.--(355 repealed Dec. 19, 1990, P.L.834, No.198)

Section 356. Distribution of Dividends on Group Insurance Policies and Group Annuity Contracts.--Any dividends hereafter declared or rate reductions hereafter made or continued for the first or any subsequent contract year under any group policy or group annuity contract heretofore or hereafter issued, may be applied to reduce the employer's part of the cost: Provided, That if, at any time, under a policy or contract, towards the cost of which the employees contribute, the aggregate of any dividends or rate reductions so applied is in excess of the employer's share of the aggregate cost, such excess shall be applied by the employer for the sole benefit of the employees.

(356 added May 26, 1937, P.L.884, No.228)

Section 357. Redomestication.--(a) Any insurer which is organized under the laws of any other state and is admitted to do business in this Commonwealth for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this Commonwealth. Said domestic insurer will be entitled to a like certificate of authority to transact business in this Commonwealth and shall be subject to the authority and jurisdiction of this Commonwealth.

(b) Any domestic insurer may, upon the approval of the Insurance Commissioner, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon such a transfer shall cease to be a domestic insurer, and shall be admitted to this Commonwealth if qualified as a foreign insurer. The Insurance Commissioner shall approve any such proposed transfer unless he shall determine such transfer is not in the interest of all the policyholders.

(c) The certificate of authority, agents appointments and licenses, rates and other items which the Insurance Commissioner allows, in his discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this Commonwealth transfers its corporate domicile to this or any other state by merger, consolidation or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this Commonwealth. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Insurance Commissioner. Every transferring insurer shall file new policy forms with the Insurance Commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by and under such conditions as approved by the Insurance Commissioner. However, every such transferring insurer shall notify the Insurance Commissioner of the details of the proposed transfer and shall file promptly
any resulting amendments to corporate documents filed or required to be filed with the Insurance Commissioner.

(357 added Dec. 18, 1992, P.L.1519, No.178)

Section 358. Service Contract Exclusion.--(a) The marketing, sale, offering for sale, issuance, making, proposing to make and administration of a service contract shall not be construed to be the business of insurance and shall be exempt from regulation as insurance.

(b) "Service contract" means a contract or an agreement for a separately stated consideration for a specific duration to perform the service, repair, replacement or maintenance of property or indemnification for service, repair, replacement or maintenance, for the operational or structural failure due to a defect in materials, workmanship or normal wear and tear with or without additional provisions for incidental payment of indemnity under limited circumstances, including, but not limited to, towing, rental and emergency road service. Service contracts may provide for the service, repair, replacement or maintenance of property for damage resulting from power surges or accidental damage from handling, provided, however, that an insurance company providing coverage or payment for towing, rental, emergency road service or mechanical breakdown insurance shall not be considered to be providing a service contract; and further provided that automobile club coverage or payment of towing, rental or emergency road service shall not be considered a service contract and shall not be regulated as insurance.


ARTICLE IV.

LIFE INSURANCE.

(a) GENERAL PROVISIONS RELATING TO STOCK AND MUTUAL COMPANIES.

Section 401. Capital of Foreign Life Insurance Companies.--Stock life insurance companies of other States and foreign governments, in order to be licensed to do business in this Commonwealth, must have a paid up and safely invested capital, if a company of another State, or a deposit in the United States, if a company of a foreign government, of not less than the capital required herein for domestic stock life insurance companies. Mutual life insurance companies, organized under the laws of any other States of the United States, may be admitted to do business in this Commonwealth if they have the requisite funds of a mutual life insurance company, and, in the opinion of the Insurance Commissioner, are in sound financial condition, and have policies in force upon not less than five hundred lives, for an aggregate amount of not less than one million dollars. Any foreign stock or mutual life insurance company, licensed to transact business in this State at the time of the passage of this act, having less capital or assets than that required herein for domestic life insurance companies, may be relicensed so long as, in the opinion of the Insurance Commissioner, it is in a sound financial condition and otherwise complies with all requirements of law.

Section 402. Compensation of Officers, Directors, Trustees, Et Cetera.--(402 repealed June 11, 1986, P.L.226, No.64)

Section 403. Vouchers for Payment of Moneys.--No domestic stock or mutual life insurance company shall make any disbursement of five hundred dollars ($500) or more unless the
same is evidenced by a voucher signed by or on behalf of the person, firm, or corporation receiving the money, and correctly describing the consideration for the payment. If the expenditure is for both services and disbursements, the voucher shall set forth the services rendered and an itemized statement of the disbursements made. If the expenditure is in connection with any matter pending before any legislative or public body, or before any department or officer of any State or government, the voucher shall correctly describe, in addition, the nature of the matter and of the interest of such company therein. When such voucher cannot be obtained, the expenditure shall be evidenced by an affidavit describing the character and object of the expenditure, and stating the reason for not obtaining such voucher.

(403 amended June 23, 1976, P.L.413, No.94)

Section 404. Investment of Capital and Reserves.--(404 repealed June 11, 1986, P.L.226, No.64)

Section 404.1. Investment Regulations.--(a) Any domestic company may invest its funds as provided in this act and not otherwise. Notwithstanding the provisions of this act, the Insurance Commissioner may, after notice and hearing, order a domestic company to limit or withdraw from certain investments, or discontinue certain investment practices, to the extent that the commissioner finds that such investments or investment practices endanger the solvency of the company. The investments of a foreign company shall be as permitted by the investment laws of its state of domicile if such laws are substantially similar to that provided by this act.

(b) No investment or loan (except loans on life policies) or an investment practice shall be made or engaged in by any domestic company unless the same has been authorized or ratified by the board of directors or by a committee thereof charged with the duty of supervising investments and loans. No such company shall subscribe to or participate in any underwriting of the purchase or sale of securities or property or enter into any agreement to withhold from sale any of its property, but the disposition of its property shall be at all times within the control of the board of directors. Any agreement or contract providing for the lawful disposition of property, wherein such disposition may be determined at the option of a third person at some specified future price or condition or specified time or upon demand, shall be construed to be within the control of the board of directors. Nothing contained in this section shall prevent the board of directors of any such company from depositing any of its securities with a committee appointed for the purpose of protecting the interest of security holders or with authorities of any state or country where it is necessary to do so in order to secure permission to transact its appropriate business therein; and nothing contained in this section shall prevent the board of directors of such company from depositing securities as collateral for the securing of any bond required for the business of the company.

(c) Any domestic company subject to the provisions of this act is required to have a formal investment plan which shall be updated on an annual basis as authorized by the board of directors. The investment plan shall include, at a minimum, a description of the investment strategy of the company designed to provide for liquidity and diversity of the investment portfolio. The investment plan, and such other information as the Insurance Department may require in order to determine the impact of the investment plan on the solvency of the company, shall be made available to the Insurance Department during the
course of a financial condition examination conducted in accordance with the laws pertaining to the conduct of examinations.

(404.1 amended Dec. 18, 1992, P.L.1519, No.178)

Section 404.2. Investment.--Subject to the provisions of sections 405.2 and 406.1, the assets of any life insurance company organized under the laws of this Commonwealth shall be invested in the following classes of investment, provided the value of which, as determined for annual statement purposes, but in no event in excess of cost, shall not exceed the specified percentage of such company's assets as of the thirty-first day of December next preceding the date of investment:

(1) Bonds, notes or obligations issued, assumed or guaranteed by the United States or by any state thereof, or by any county, city, town, village, municipality or district therein or by any political subdivision thereof or by a public instrumentality of one or more of the foregoing, if, by statutory or other legal requirements applicable thereto, such obligations are payable, as to both principal and interest, from taxes levied, or required to be levied, upon all taxable property or all taxable income within the jurisdiction of such governmental unit, or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment; but not including any obligation payable solely out of special assessments on properties benefited by local improvements, unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation additionally secured by an adequate guaranty fund required by law.

(2) Bonds, notes, obligations and in stock where stated, issued, assumed or guaranteed by the following agencies of the United States, or in which such government is a participant, whether or not such obligations are guaranteed by such government:
   (i) Farm Loan Bank.
   (ii) Commodity Credit Corporation.
   (iii) Federal intermediate credit banks.
   (iv) Federal land banks.
   (v) Central Bank for Cooperatives.
   (vi) Federal home loan banks and stock thereof.
   (vii) Federal National Mortgage Association and stock thereof.
   (viii) International Bank for Reconstruction and Development.
   (ix) Inter-American Development Bank.
   (x) Asian Development Bank.
   (xi) African Development Bank.
   (xii) Any other similar agency of, or participated in by, the government of the United States and of similar financial quality, which such investments the Insurance Commissioner has determined were of similar financial quality.

(3) Bonds, notes, obligations or other investments of or in any business or governmental unit in or of any foreign country which are of the same kinds, classes and investment grades as those eligible for investment under this section. Investments under this clause in the Dominion of Canada shall not exceed ten per centum (10%) of such company's admitted assets. Investments under this clause in all other foreign countries shall not exceed ten per centum (10%) of such company's admitted assets except as provided in section 406.1(a).
(4) Business obligations:
   (i) Bonds, notes or obligations issued, assumed, guaranteed or accepted by any corporation, joint-stock association, business trusts, business partnerships and business joint ventures, incorporated or existing under the laws of the United States or of any state, district or territory thereof.
   (ii) Preferred stock of any of the foregoing.
   (iii) Interest-bearing deposits or certificates of deposits in banks, bank and trust companies, savings banks, savings associations, savings and loan associations or national banking associations, incorporated or existing under the laws of the United States or any state, district or territory thereof and branches of foreign banking institutions located in the United States or any state, district or territory thereof.
   (iv) Obligations which are not issued, assumed, guaranteed or accepted by any person described under subclause (i) but are secured by an assignment of a right to receive rent, purchase or other payment or revenues for the use or purchase of real or personal property sufficient to repay the investment and payable or guaranteed by any one or more persons or entities whose bonds, notes or obligations would qualify for investment under this section or a mortgage, interest in mortgage pool or mortgage participation, or lien or security interest in real or personal property or any interest therein. Investments permitted under subclause (ii) shall not exceed twenty-five per centum (25%) of such company's admitted assets, and no investment in any single corporation or entity contemplated by this clause shall exceed five per centum (5%) of such company's admitted assets.

(5) Trustees', receivers' or equipment trust obligations:
   (i) Certificates, notes or obligations issued by trustees or receivers of any corporation or business trust created or existing under the laws of the United States or of any state, district or territory thereof which, or the assets of which, are being administered under the direction of any court having jurisdiction, if such obligation is adequately secured as to principal and interest.
   (ii) Equipment trust obligations or certificates, which are adequately secured, or other adequately secured instruments, evidencing an interest in transportation equipment, wholly or in part within the United States, and a right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of such transportation equipment.

(6) Obligations secured by real property or any interests therein, obligations or participations therein, secured by liens on real property or interests therein, located within the United States, district or territory thereof. The value of such real property or interest, together with such other security as shall secure any such obligation, shall be adequate to secure the investment as well as any lien senior to the lien created by the investment in such real estate. No investment in a single transaction shall exceed an amount equal to five per centum (5%) of such company's admitted assets.

(7) Loans upon the security of its own policies not exceeding the net value of the policy at the time of making the loan.

(8) Such real estate or interests therein located in any state, district or territory of the United States as such company is authorized to hold under this act.

(9) Subsidiaries as permitted under this act.
(10) Equity interests:

(i) Investments (other than investments provided for in section 406, clauses (11) and (13) of this section 404.2 and investments in subsidiaries as provided for in section 405.2(c)) in common stocks, limited partnership interests, trust certificates (except equipment trust certificates described in clause (5)) or other equity interests (other than preferred stocks) of corporations, joint-stock associations, business trusts, business partnerships and business joint ventures incorporated, organized or existing under the laws of the United States, or of any state, district or territory thereof.

(ii) Stocks or shares of any regulated investment company which is registered as an investment company under the Federal Investment Company Act of 1940 (54 Stat 789, 15 U.S.C. §§ 80a-1 to 80a-52, 107), as, from time to time, amended, and which has no preferred stock, bonds, loans or any other outstanding securities having preference or priority as to the assets or earnings over its common stock at the date of purchase.

(iii) Investments under this clause shall not exceed twenty-five per centum (25%) of such company's admitted assets, and no investment in any single corporation or entity contemplated by this clause shall exceed five per centum (5%) of such company's admitted assets. The limitations set forth in this clause shall not apply to investments in any corporation or entity which is an insurance company or a health maintenance organization holding a certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(iv) Limited partnership interests under this clause shall not exceed ten per centum (10%) of the company's admitted assets. A company may not invest more than ten per centum (10%) of its capital and surplus in any one such limited partnership.

((10) amended Dec. 21, 1995, P.L.714, No.79)

(11) Investments in or investments in interests in machinery, equipment, facilities, furnishings, fixtures or other tangible personal property used for, in or as part of or connected with any commercial, industrial, manufacturing, processing or financial, business activity or operation and which may be subject to contractual or other similar arrangements for the purchase, sale or use thereof. Investments in this clause shall not exceed fifteen per centum (15%) of such company's admitted assets.

(12) Derivative transactions. An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the conditions set forth in this section.

(i) General conditions:

(A) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the Insurance Commissioner.

(B) An insurer shall be able to demonstrate to the Insurance Commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

(ii) Limitations on hedging transactions. An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(A) the aggregate statement value of options, caps, floors and warrants not attached to another financial instrument
purchased and used in hedging transactions does not exceed seven and one-half per centum (7.5%) of its admitted assets;
(B) the aggregate statement value of options, caps and floors written in hedging transactions does not exceed three per centum (3%) of its admitted assets; and
(C) the aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half per centum (6.5%) of its admitted assets.

(iii) Limitations on income generation transactions. An insurer may enter into the following types of income generation transactions only if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten per centum (10%) of its admitted assets:
(A) sales of covered call options on noncallable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period or derivative instruments based on fixed income securities;
(B) sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;
(C) sales of covered puts on investments that the insurer is permitted to acquire under this section, if the insurer has escrowed or entered into a custodian agreement segregating cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put options sold; or
(D) sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(iv) Counterparty exposure. An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of clause (13).

(v) Additional transactions. Additional transactions may be approved involving the use of derivative instruments in excess of the limits of subclause (ii) or for other risk management purposes under regulations promulgated by the Insurance Commissioner, but replication transactions shall not be permitted for other than risk management purposes.

(vi) Definitions:
(A) "Call option" means an agreement giving a right to buy or receive an interest based on the actual or expected price, level, performance or value of one or more underlying interests.
(B) "Cap" means an agreement obligating a seller to make payments to a buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the "strike rate" or "strike price."
(C) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.
(D) "Counterparty exposure amount" means:
The net amount of credit risk attributable to a derivative instrument entered into with a business entity other than an over-the-counter derivative instrument. The amount of credit risk equals:

(a) the market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(b) zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(II) If over-the-counter derivative instruments are entered into under a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting, the amount of credit risk shall be the greater of zero or the net sum of:

(a) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(b) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(III) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(E) "Covered" means that an insurer owns or can immediately acquire, through the exercise of options, warrants or conversion rights already owned, the underlying interest in order to fulfill or secure its obligations under a call option, cap or floor it has written, or has set aside under a custodial or escrow agreement cash or cash equivalents with a market value equal to the amount required to fulfill its obligations under a put option it has written, in an income generation transaction.

(F) "Derivative instrument" means an agreement, option, instrument or a series or combination of agreements, options or instruments:

(I) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(II) that has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(G) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(H) "Floor" means an agreement obligating a seller to make payments to a buyer in which each payment is based on the amount that a predetermined number, sometimes called the "floor rate" or "floor price," exceeds a reference price, level, performance or value of one or more underlying interests.

(I) "Forward" means an agreement, other than a future, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(J) "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery
of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(K) "Hedging transaction" means a derivative transaction that is entered into and maintained to reduce:

(I) the risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(II) the currency exchange rate risk or the degree of exposure as to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring.

(L) "Income generation transaction" means a derivative transaction involving the writing of covered call options, covered put options, covered caps or covered floors that is intended to generate income or enhance return.

(M) "Investment subsidiary" means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if the subsidiary agrees to limit its investment in any asset so that its investment will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or violate any other provision applicable to the insurer. As used in this definition, the total investment of the insurer shall include:

(I) direct investment by the insurer in an asset; and

(II) the insurer's proportionate share of an investment in an asset by an investment subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership interest in the subsidiary.

(N) "Option" means an agreement giving a right to buy or receive, sell or deliver, enter into, extend or terminate or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

(O) "Over-the-counter derivative instrument" means a derivative instrument entered into through a qualified exchange or qualified foreign exchange or cleared through a qualified clearinghouse.

(P) "Put option" means an agreement giving a right to sell or deliver an interest based on the actual or expected price, level, performance or value of one or more underlying interests.

(Q) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this article. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(R) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

(S) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity.

((12) amended July 9, 2010, P.L.362, No.51)

(13) General three per centum (3%) diversification.

(i) Except as otherwise specified in this section, an insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under this section if, as
a result of and after giving effect to the investment, the insurer would hold more than three per centum (3%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured or guaranteed by a single person, or five per centum (5%) of its admitted assets in investment in the voting securities of a depository institution or any company that controls the institution.

(ii) The three per centum (3%) limitation under subclause (i) shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(iii) Asset-backed securities shall not be subject to the limitations of subclause (i), but an insurer shall not acquire an asset-backed security if, as a result of an after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity then held by the insurer would exceed three per centum (3%) of its admitted assets.

((13) amended July 9, 2010, P.L.362, No.51)

(14) Investment in properties and facilities for the exploration, development, production and distribution of energy-producing substances. Such investments may include ownership and control of such properties and facilities or interests therein, including royalty interests and production payments from such activities or investments in limited partnerships engaged in such activities. Investments under this clause shall not exceed five per centum (5%) of such company's admitted assets. The investments in activities producing royalty interests and production payments shall not exceed an additional ten per centum (10%) of such company's admitted assets. An additional one per centum (1%) of such company's assets may be invested in properties, facilities, royalty interests or production payments under this clause, provided that such properties and facilities are located in or operated principally in this Commonwealth.

(15) Lending of securities, repurchase agreements and reverse repurchase agreements:

(i) Definitions:

(A) "Lending of securities" means an investment, other than a repurchase agreement, whereby an agreement is entered into which transfers ownership rights and possession of securities to the borrower of such securities with the agreement providing for a return of ownership rights and possession of the securities to the lender at a specified date or upon demand.

(B) "Repurchase agreement" means a bilateral agreement whereby a company purchases securities with a related agreement that the seller will purchase or repurchase at a specified price the equivalent or similar securities within a specified period of time or on demand.

(C) "Reverse repurchase agreement" means a bilateral agreement whereby a company (i) sells securities with a related agreement to purchase or repurchase at a specified price the equivalent or similar securities within a specified period of time or upon demand or (ii) borrows funds and transfers securities to the lender with a related agreement that equivalent or similar securities will be returned to the company upon repayment of the loan within a specified period of time or on demand.
(ii) Lending of securities, repurchase agreements and reverse repurchase agreements transactions are authorized on the following conditions:

(A) The agreement for each transaction or the master agreement for a series of transactions shall be reduced to writing.

(B) Securities acquired by a company and owned subject to reacquisition pursuant to an outstanding repurchase agreement may not be sold pursuant to a reverse repurchase agreement nor lent pursuant to a lending of securities agreement. Consideration, or collateral, received from a reverse repurchase agreement or lending of securities agreement may be used to acquire securities which are equivalent or similar to the securities transferred pursuant to such repurchase agreement or lending of securities agreement; however, such acquired securities may not be sold pursuant to a reverse repurchase agreement nor lent pursuant to a lending of securities agreement.

(C) A company is limited to no more than five per centum (5%) of its admitted assets being subject to lending of securities, repurchase or reverse repurchase agreements transactions outstanding with any one business entity under this clause (15).

(D) A company may engage in lending its securities or repurchase or reverse repurchase agreements up to forty per centum (40%) of its admitted assets, provided that such transactions are fully collateralized.

(E) The Insurance Commissioner may promulgate reasonable rules and regulations for investments and transactions under this clause (15), to include, but not be limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.


(16) Other loans and investments:

(i) Loans or investments not authorized by any of the clauses of this section to an amount not exceeding the aggregate of twenty per centum (20%) of such company's admitted assets. The twenty per centum (20%) limitation provided above shall be increased in the same amount that investments approved by the Insurance Commissioner are made in the following categories of investments provided that their principal operations or locations are located in this Commonwealth:

(A) Investments in venture capital limited partnerships or in new and young small businesses which are making an initial public offering of securities or utilizing a limited private placement.

(B) Investments in minority-owned and operated businesses domiciled in Pennsylvania as provided in the act of July 22, 1974 (P.L.598, No.206), known as the "Pennsylvania Minority Business Development Authority Act."

(C) Investments in businesses located in enterprise zones designated by the Department of Community Affairs.

(D) Investments in housing for families and persons of low income or in housing in enterprise zones designated by the Department of Community Affairs.

(E) Investments in seed capital funds established pursuant to the provisions of the act of July 2, 1984 (P.L.555, No.111), known as the "Small Business Incubators Act."

(F) Investments in business development credit corporations established pursuant to the act of December 1, 1959 (P.L.1647, No.606), known as the "Business Development Credit Corporation Law."
(G) Investments in small business investment corporations and minority enterprise small business investment companies certified pursuant to applicable Federal laws. In no event may the percentage limitation under this subclause (i) exceed the aggregate of twenty-five per centum (25%).

(H) Investments in and direct management of or participation in private placement accounts, including investments by private and public employe pension funds, and investments in and direct management of or participation in long and intermediate loans to small and large corporations within Pennsylvania for purposes such as plant construction, equipment purchases and working capital.

(I) Investments in, and financial assistance to, Pennsylvania-based employe-owned enterprises, as defined and described by the Internal Revenue Code of 1954, including worker cooperatives, employe stock ownership plans and businesses in which a majority of the voting rights are held or controlled by employes or held in trust for and passed through to employes.

(J) Investments in, and financial assistance to, Pennsylvania-based employe-ownership groups, including corporations, labor unions or other entities formed by, or on behalf of, the current or former employes of an industrial or commercial firm or facility for the purpose of assuming ownership or control of the firm or facility and operating it as an employe-owned enterprise.

(K) Investments in construction loans to builders and developers of low-income to moderate-income housing in Pennsylvania involved in the new construction or rehabilitation of single-family or multi-family housing in census tracts or neighborhoods, in both urban and rural communities, designated by State or Federal law as economically deprived or financially underserved, and mortgage loans and other credit to individuals seeking to purchase this type of housing.

(ii) For each one-half per centum (.5%) of such company's admitted assets invested in categories (A) through (G) of subclause (i) of this clause whose principal operations or locations are located in this Commonwealth, investments under other clauses of this section may exceed the volume limitations set forth in such other clauses by an aggregate of two and one-half per centum (2.5%) of the company's admitted assets, but in no event may such excess investments exceed a maximum of five per centum (5%) of admitted assets; however, such excess investments shall be charged against the limitation established in subclause (i) of this clause.

(17) (i) Investments shall be valued in accordance with the published valuation standards of the National Association of Insurance Commissioners. Securities investments as to which the National Association of Insurance Commissioners has not published valuation standards in its valuation of securities manual or its successor publication shall be valued as follows:

(A) Any investment by any insurer that is not valued by Standards published by the National Association of Insurance Commissioners shall, at the time of acquisition, be submitted to the National Association of Insurance Commissioners for evaluation.

(B) Other securities investments shall be valued in accordance with regulations promulgated by the Insurance Commissioner pursuant to subclause (iv) of this clause.

(ii) Other investments, including real property, shall be valued in accordance with regulations promulgated by the Insurance Commissioner pursuant to subclause (iv) of this clause.
clause, but in no event shall such other investments be valued at more than their purchase price. Purchase price for real property includes capitalized permanent improvements, less depreciation spread evenly over the life of the property or, at the option of the company, less depreciation computed on any basis permitted under the Internal Revenue Code of 1954 (68A Stat. 3, 26 U.S.C. § 1 et seq.) and regulations thereunder. Such investments that have been affected by an impairment, other than a temporary decline, in value shall be valued at not more than their market value.

(iii) Any investment, including real property, not purchased by a company but acquired in satisfaction of a debt or otherwise, shall be valued in accordance with the accounting procedures and practices developed by the National Association of Insurance Commissioners as required by the law relating to the filing of annual financial statement blanks.

(iv) The Insurance Commissioner may promulgate rules and regulations for determining and calculating values to be used in financial statements submitted to the Insurance Department for investments not subject to published National Association of Insurance Commissioners' valuation standards.

((17) amended Dec. 18, 1992, P.L.1519, No.178)
(404.2 added June 11, 1986, P.L.226, No.64)

Compiler's Note: Section 301(a)(9) of Act 58 of 1996, which created the Department of Community and Economic Development and abolished the Department of Community Affairs, provided that housing, community assistance and other functions under section 404.2 are transferred from the Department of Community Affairs to the Department of Community and Economic Development.

Section 405. Investment of Surplus and Balance of Reserve.--(405 repealed June 11, 1986, P.L.226, No.64)

Section 405.1. Acquisition and Retention of Subsidiary Life Insurance Companies by Life Insurance and Limited Life Insurance Companies Organized Under the Laws of This Commonwealth.--(405.1 repealed June 11, 1986, P.L.226, No.64)

Section 405.2. Additional Investment Authority for Subsidiaries.--(a) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Insurance company" or "insurer" includes any company, association or exchange authorized to conduct an insurance business in the jurisdiction of its domicile.

"NAIC" means the National Association of Insurance Commissioners.

"Owner" or "holder" of securities of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

"Person" is an individual, corporation, partnership, association, joint-stock company, business trust, unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

"Subsidiary" shall mean only a corporation in which another person owns or holds, with the power to vote directly or through one or more intermediaries, a majority of the outstanding voting securities. A person whose business consists primarily of real property and interests therein, or a corporation which is held in a separate account pursuant to section 406.2, shall not be deemed a subsidiary for the purposes of determining the volume
limitations set forth in subsection (c)(1). A person which is controlled by another person solely as a result of the temporary assumption of control by the owner of securities upon the happening of a prescribed event of default shall not be deemed a subsidiary or affiliate for purposes of this section, if such securities are disposed of within five years from the date of acquisition, unless such period is extended by the Insurance Commissioner to enable the owner to dispose of such securities in a reasonable and orderly manner.

"Voting security" means stock of any class or any ownership interest having the power to elect the directors, trustees or management of a person, other than securities having such power only by reason of the happening of a contingency.

(b) Any domestic life insurance company, either by itself or in cooperation with one or more persons, may, in addition to any authority to acquire or hold securities in corporations provided for elsewhere in this act, organize or acquire one or more subsidiaries. Such subsidiaries may conduct any kind of business or businesses, and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic life insurance company. No domestic life insurance company shall be deemed to be authorized to participate in or to form a general partnership with any other person.

(c) (1) Except as set forth in paragraph (1.1), at no time shall a domestic life insurance company make an investment in any subsidiary which will bring the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) of its total admitted assets as of the immediately preceding thirty-first day of December. In determining the amount of investments of any domestic life insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose.

(1.1) A domestic life insurance company may increase the aggregate value of its investments, as determined for annual statement purposes, but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) but at no time in excess of fifteen per centum (15%) of its total admitted assets as of the immediately preceding thirty-first day of December if the increase has been approved in writing by the Insurance Department prior to making the investment. If the Insurance Department does not approve or disapprove the increased investment within thirty (30) days of receipt of a request for approval, the increased investment shall be deemed approved. In determining the amount of investments of any domestic life insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose.

(2) The limitations set forth in clauses (1) and (1.1) of this subsection shall not apply to investments in any subsidiary which is:

(i) An insurance company or a health maintenance organization holding a certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."
(ii) A holding company to the extent its business consists of the holding of the stock of, or otherwise controlling, its own subsidiaries.

(iii) A corporation whose business primarily consists of direct or indirect ownership, operation or management of assets authorized as investments pursuant to sections 404.1 and 406.

(iv) A company engaged in any combination of the activities described in subclauses (i), (ii) and (iii) of this clause. Investments made pursuant to subclause (i) shall not be restricted in amount provided that after such investment, as calculated for NAIC annual statement purposes, the insurer's surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. Investments made pursuant to subclause (ii), or to the extent applicable in this subclause, shall in addition not be subject to any limitations on the amount of a domestic life insurance company's assets provided for under any other provision of this act and which might otherwise be applicable: Provided, however, That such life insurance company's investments, to the extent that such life insurance company provided the funds therefor, in each of the subsidiaries of such holding company shall be subject to the limitations, if any, applicable to such investment as if the holding company's interest in each such subsidiary were instead owned directly by the life insurance company. Investments made pursuant to subclause (iii), or, to the extent applicable, this clause, shall be counted in determining the limitations contained in applicable subsections of sections 404.2 and 406: Provided, however, That the value as calculated for annual statement purposes, but not in excess of the cost thereof, of such investment shall include only funds provided by the insurance company therefor. Investments made in other subsidiaries of such life insurance company by any subsidiary described in subclauses (i), (ii), (iii) and this subclause or by a person whose business primarily consists of direct or indirect ownership, operation or management of real property and interest therein under section 406 shall be deemed investments made by the insurance company only to the extent the funds for such investment were provided by such insurance company.

(c) amended July 9, 2008, P.L.885, No.62)

(d) No restrictions, prohibitions or limitations contained in this act otherwise applicable to investments of domestic life insurers shall be applicable to investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (c); nor shall the additional investment authority granted by subsection (c) have the effect of restricting, prohibiting or limiting the rights of a domestic life insurer to make investments permitted under any other section of this act.

(e) Whether any investment made pursuant to subsection (c) meets, at any time thereafter, the applicable requirements thereof is to be determined when such investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value, but not in excess of the cost thereof, of all previous investments in equity securities as calculated for annual statement purposes. In calculating the amount of such investments, there shall be included, as determined for NAIC annual statement purposes:

(1) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether
or not represented by the purchase of capital stock or issuance of other securities.

(2) All amounts expended by the domestic life insurance company in acquiring additional common stock, preferred stock debt obligations, and other securities and all contributions to the capital or surplus, or a subsidiary subsequent to its acquisition or formation.

(f) If a domestic life insurer ceases to own, directly or indirectly through one or more intermediaries, a majority of the voting securities of a subsidiary held pursuant to subsection (c), it shall dispose of any investment therein made pursuant to such subsection within five years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless, at any time after such investment shall have been made, such investment shall have met the requirements for investment under any other section of this act.

(405.2 added June 11, 1986, P.L.226, No.64)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 406. Real Estate Which May Be Purchased, Held or Conveyed.—Subject to the provisions of section four hundred six, point one, it shall be lawful for any life insurance company, organized under the laws of this Commonwealth, directly or indirectly, alone or together with one or more persons or entities, to purchase, receive, hold and convey, real estate or any interest therein:

(a) Required for its convenient accommodation in the transaction of its business with reasonable regard to future needs; including residential real estate purchased from employees transferred or about to be transferred to new places of employment with such company.

(b) Acquired in satisfaction or on account of loans, mortgages, liens, judgments or decrees, previously owing to it in the course of its business;

(c) Acquired in part payment of the consideration of the sale of real property owned by it if the transaction shall result in a net reduction in the company's investment in real estate;

(d) Reasonably necessary for the purpose of maintaining or enhancing the sale value or real property previously acquired or held by it under subsections (a), (b) or (c) of this section;

(f) Purchased, leased or owned for residential, business, commercial or industrial use, or for development, improvement, maintenance or construction and maintenance. The aggregate cost of investments in unimproved real estate under this subsection shall not, however, exceed the lesser of ten per centum (10%) of the company's admitted assets or forty-five per centum (45%) of its capital and surplus. Investments under this subsection, including investments in limited partnership interests or other entities where said entities are engaged primarily in holding real estate or interests therein under this subsection and corporations which are engaged primarily in holding real estate or interests therein as defined in this subsection and the majority of whose voting securities are owned directly or indirectly through one or more intermediaries, shall not exceed twenty-five per centum (25%) of such company's admitted assets. 

((f) amended Dec. 18, 1992, P.L.1519, No.178)

(406 amended June 11, 1986, P.L.226, No.64)
Section 406.1. General Investment Provisions and Restrictions.--Investment under authority of section 404.2 and holding of real estate under authority of section four hundred six by any life insurance company, organized under the laws of this Commonwealth, shall be subject to the following provisions:

(a) The Insurance Commissioner may permit such company to invest sufficient of its assets exclusive of the amounts permitted in section 404.2(3) in the securities of a foreign government in order to comply with the laws of such foreign government and transact business in such foreign country.

(b) No investment under section 404.2 or 406 shall be made in the equity interest, as defined in section 404.2(10), of any unincorporated business or enterprise other than a business trust, joint-stock company or limited partnership in which a life insurance company acts as a limited partner. A subsidiary of a life insurance company may act as a general partner.

(c) No investment shall be made in any loan solely upon personal security of an individual or individuals, but nothing in this act shall be construed to prevent the taking of a bona fide obligation with legal interest in payment of any premium or a loan for defraying in whole or in part the expenses of an employee transferred or about to be transferred to a new place of employment with such company.

(d) No investment shall be made by any life insurance company in any loan upon the stock, shares or obligation of such company or any other insurance company transacting like classes of business but any stock life insurance company may, with the approval of its board of directors, acquire, retain, cancel or dispose of shares of its own capital stock: Provided, That (i) no such company shall acquire such stock without the prior approval of the Insurance Commissioner, (ii) no such company shall effect a reduction in its capital stock without complying with the applicable provisions of the law, and (iii) no such company shall directly or indirectly vote shares of its own stock held by it.

(k) With the approval of the Insurance Commissioner such company may enter into agreements with one or more insurance companies authorized to do business in this Commonwealth, whereby such companies shall participate in ownership, management and control of real estate held or to be acquired by such company or companies under subsection (f) of section four hundred six, or held by a corporation whose stock is held or to be acquired by such company or companies.

(m) No provision of this act shall be so construed as to prevent any such company from investing any of its assets, or from holding any of such funds in cash or deposits in banks or trust companies or from acquiring or holding property taken in reorganization or foreclosure proceedings or which may be obtained in satisfaction of or on account of any debt previously contracted.

(n) Any such company may continue its investment of any of its assets in any corporate bonds, notes or obligations held by it on the effective date of this amendment, under authority of section four hundred four, as amended by the act, approved the twelfth day of May, one thousand nine hundred and thirty-nine (Pamphlet Laws 131).

(q) "Date of Investment" shall mean the date of commitment in the case of a commitment to invest.

(r) If any investment is made in a manner not authorized by this act, the officers, directors and trustees making or authorizing such investment, shall be personally liable for any loss occasioned thereby.
"State" shall mean any state, district or territory, including Puerto Rico, the Virgin Islands of the United States and the District of Columbia.

(406.1 amended June 11, 1986, P.L.226, No.64)

Section 406.2. Separate Accounts.--(a) Any life insurance company organized under the laws of this Commonwealth may establish one or more separate accounts and may allocate thereto any amounts (including without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life insurance or annuities (and benefits incidental thereto) payable in fixed or variable amounts or both, and for any other investment purpose consistent with a company's investment powers under sections 404.2, 406 and 406.1 or this subsection in connection with any product permissible to such company under this act and subject to the following:

(1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall, in accordance with applicable contracts, be credited to or charged against such account, without regard to other income, gains or losses of the company. Life insurance companies may maintain one or more separate accounts subject to reasonable regulations promulgated by the commissioner with respect to:

(i) Separate accounts with all or any portion of the benefits guaranteed as to dollar amounts and duration.

(ii) Separate accounts with all or any portion of the funds guaranteed as to the principal amount or stated rate of interest.

(2) Except as herein provided, the amounts allocated to each separate account established by the insurer pursuant to this section, together with any accumulations thereon, may be invested and reinvested in any class of investments which may be authorized in the written contract or agreement without regard to any investment limitations otherwise applicable to the investment of life insurance companies. The investments in such separate account or accounts shall not be taken into account in the investment limitations applicable to the investments of the insurance company under the provisions of this act.

(3) Assets allocated to a separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value. If there is no readily available market value, then such assets shall be valued as provided under the terms of the contract or the rules or other written agreement applicable to such separate account or by regulation prescribed by the commissioner.

(5) Amounts allocated to a separate account shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct. Sales, exchanges or other transfers of assets may be made by a company at any time between any of its separate accounts or between any other investment account and one or more of its separate accounts provided that the transfer into or from a separate account is made by:

(i) A transfer of cash.

(ii) A transfer of assets having a valuation which could be readily determined in the marketplace.
(iii) Such other transfers as the commissioner in his discretion may approve.

(6) If pursuant to the terms of the applicable contracts amounts allocated to a separate account are to be invested in shares of a specified investment company registered under the Investment Company Act of 1940, as amended, which shares are to be held for the exclusive benefit of the applicable contracts, such shares shall, if and to the extent provided in the applicable contracts, be deemed to be a separate account pursuant to the provisions of section 406.2.

(8) To the extent the company deems it necessary to comply with any applicable Federal or State laws, such company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account.

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

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

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

(2) The character, responsibility and general fitness of the officers and directors or trustees of the company, and whether such individuals command the public confidence and warrant the belief that the business of the company will be honestly and efficiently conducted in accordance with the intent and purpose of this act; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts. The state of entry of an alien company shall be deemed its place of domicile for this purpose.

If the company is a subsidiary of an admitted life insurance company, or affiliated with such company through common management or ownership, it may be deemed by the Insurance Commissioner to have met the provisions of this section if either it or the parent or the affiliated company meets the requirements hereof.

(d) Notwithstanding any other provision of law, the Insurance Commissioner shall have sole authority to regulate
the issuance and sale of variable contracts, including the approval or disapproval of provisions of the contracts under section 354 of this act, and, further including annual statements furnished to contract holders, and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of section 406.2 in the public interest, including that the premiums to be charged shall not be excessive, inadequate or unfairly discriminatory, and the prevention of excessive management, administrative and sales charges. Variable contracts, and agents or other persons who sell variable contracts, shall not be subject to the act of December 5, 1972 (P.L.1280, No.284), known as the "Pennsylvania Securities Act of 1972," or to regulation by the Pennsylvania Securities Commission.

(f) Except for sections 410(b), 410(c), 410(h), 410(i), 410(j), 410(k) and 410A of The Insurance Company Law of 1921 and section 6(1) of the act of May 11, 1949 (P.L.1210, No.367), entitled "An act relating to group life insurance; describing permitted policies and restrictions thereon, the premium basis thereof and rights thereunder; limiting the amount of such insurance; prescribing standard policy provisions; and requiring notice of conversion privileges," in the case of variable life insurance contract and sections 410B(a), 410B(f), 410B(g), and 410B(3) of The Insurance Company Law of 1921 in the case of a variable annuity contract and except as otherwise provided in section 406.2, all pertinent provisions of the insurance laws shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance or variable annuity contract, delivered or issued for delivery in this Commonwealth shall contain grace, reinstatement, incontestability, nonforfeiture and right to review provisions as shall be provided in rules and regulations established by the commissioner appropriate to such contract; and any group variable life insurance contract, delivered or issued for delivery in this Commonwealth shall contain a grace provision as shall be provided in rules and regulations established by the commissioner appropriate for such contract.

The reserve liability for variable contracts shall be established in accordance with actuarial procedures acceptable to the Insurance Commissioner that recognize the variable nature of the benefits provided and any mortality guarantees.

((f) amended Dec. 18, 1996, P.L.1003, No.154)
(406.2 amended June 11, 1986, P.L.226, No.64)

Section 407. Penalty.--Subject to the provisions of subsection (a) of section 406 and subsection (c) of section 406.1, no director, trustee, or officer of any stock or mutual life insurance company, incorporated under any law of this Commonwealth, shall receive any money or valuable thing for negotiating, procuring, recommending, or aiding in any purchase by, or sale to, such company of any property, or any loan from such company; nor be directly or indirectly pecuniarily interested, either as principal, co-principal, agent, or beneficiary, in any such purchase, sale, or transaction. Any person violating any provision of this section shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to pay a fine not exceeding five hundred dollars.

(407 amended June 2, 1965, P.L.77, No.54)

Section 408. Procedure in Case of Impairment of Reserve Liability.--No stock or mutual life insurance company, after receiving notice from the Insurance Commissioner that its reserve liability, after all other debts and claims against it, including fifty per centum of its capital, have been deducted,
has been impaired, shall issue new policies, under its authority
to do business in this Commonwealth, until its funds have become
equal to its liabilities and it has obtained from the Insurance
Commissioner a certificate to that effect, with authority to
resume business. When a life insurance company organized under
the laws of this Commonwealth has been notified to cease doing
new business, the Insurance Commissioner may, in case it appear
from his examination that no fraud or gross incompetence or
recklessness is shown to exist in the management, permit the
officers of the company to continue in charge of its business
for one year; and he may renew the permission, if he is
satisfied that the company is likely to retrieve its affairs,
or he may institute proceedings to determine what further shall
be done.

Section 409. Form of Policies To Be Filed With Insurance
Commissioner; Objections; Review by Court.--(409 repealed July
19, 1951, P.L.1100, No.245)

Section 410. Uniform Policy Provisions.--No policy of life
or endowment insurance, except policies of industrial insurance
where the premiums are payable monthly or oftener, shall
hereafter be delivered in this Commonwealth unless it contains,
in substance, the following provisions or provisions which, in
the opinion of the Insurance Commissioner, are more favorable
to the policyholder:--
(a) A provision that all premiums shall be payable in
advance.
(b) A provision that the insured is entitled to a grace,
either of thirty days or one month, within which the payment
of any premium after the first year may be made, subject, at
the option of the company, to an interest charge not in excess
of eight per centum per annum for the number of days of grace
elapsing before the payment of the premium, during which period
of grace the policy shall continue in full force; but in case
the policy becomes a claim during the said period of grace,
before the overdue premium, or the deferred premiums of the
current policy year, if any, are paid, the amount of such
premiums, with interest on any overdue premiums, may be deducted
in any settlement under the policy. ((b) amended Apr. 8, 1982,
P.L.297, No.84)
(c) A provision that the policy shall be incontestable after
it has been in force, during the lifetime of the insured, two
years from its date of issue, except for nonpayment of premiums;
and that, at the option of the company, provisions relative to
disability benefits, and provisions which grant additional
insurance specifically against death by accident or accidental
means, may also be excepted.
(d) A provision that the policy shall constitute the entire
contract between the parties; but if the company desires to
make the application a part of the contract, it may do so,
provided a copy of such application shall be endorsed upon or
attached to the policy when issued, and in such case the policy
shall contain a provision that the policy and the application
therefor shall constitute the entire contract between the
parties.
(e) A provision that, if the age of the insured or of any
other person whose age is considered in determining the premium
has been misstated, the amount payable or benefit accruing under
the policy shall be such as the premium would have purchased
at the correct age or ages.
(f) A provision that the policy shall participate in the
surplus of the company, and that, beginning not later than the
end of the third policy-year, the company will annually
determine the portion of the divisible surplus accruing on the policy, and that the party entitled to elect such option shall have the right to have the dividend arising from such participation paid in cash, or applied in accordance with any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective, if such party shall not have elected some other option.

In lieu of the foregoing provisions, the policy may contain a provision that the policy shall participate in the surplus of the company, and that, beginning not later than the end of the fifth policy-year, the company will determine the portion of the divisible surplus accruing on the policy, and that the party entitled thereto shall have the right to have the current dividend arising from such participation paid in cash, and that, at periods of not more than five years thereafter, such apportionment and payment, at the option of such party, shall be had.

Renewable term policies of ten years or less may provide that the surplus accruing to such policies shall be determined and apportioned each year after the second policy-year, and accumulated during each renewal period, and that at the end of any renewal period, or renewal of the policy by the insured, the company shall apply the accumulated surplus as an annuity for the next succeeding renewal term in the reduction of premiums.

(g) A provision specifying the options if any to which the policyholder is entitled in the event of default in a premium payment.

(h) A provision for a loan value at any time after three full years' premiums have been paid and while no premium is in default beyond the grace period of payment.

(1) In the case of any policy issued prior to the operative date of section four hundred and ten A of this act (the Standard Non-forfeiture Law), it shall be provided that the company will advance, on proper assignment or pledge of the policy, and on the sole security thereof, at a specified rate of interest, a sum equal to, or, at the option of the owner of the policy, less than, the reserve at the end of the current policy year on the policy, and on any dividend additions thereto, less a sum not more than two and one-half per centum of the amount insured by the policy and of any dividend additions thereto; and that the company will deduct from such loan value any existing indebtedness on the policy, and any unpaid balance of the premium for the current policy-year, and may collect interest in advance on the loan to the end of the current policy-year; which provision may further provide that such loan may be deferred for not exceeding six months after the application therefor is made. A company may, in lieu of the provision hereinabove permitted for the deduction from a loan on the policy of a sum not more than two and one-half per centum of the amount insured by the policy and of any dividend additions thereto, insert in the policy a provision that one-fifth of the entire reserve may be deducted in case of a loan under the policy; or may provide therein that the deduction may be the said two and one-half per centum, or the one-fifth of the said entire reserve, at the option of the company.

(2) In the case of any policy issued on or after the operative date of section four hundred and ten A of this act (the Standard Nonforfeiture Law for Life Insurance), the loan provision shall provide that the company will advance, on proper
assignment or pledge of the policy, and on the sole security thereof, at a specified rate of interest not exceeding eight per centum per annum for policies issued prior to the effective date of section four hundred and ten F, a sum equal to, or, at the option of the party entitled thereto, less than, the cash surrender value at the end of the current policy year as required by section four hundred and ten A of this act; and that the company may deduct from such loan value (in addition to any indebtedness deducted in determining such value) any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. The company shall reserve the right to defer such loan, except any made to pay premiums to the company, for six months after application therefor is made. This subsection (h) shall not apply to term insurance. ((2) amended Apr. 8, 1982, P.L.297, No.84)

(i) A provision for a non-forfeiture and cash surrender value.

(1) In the case of any policy issued prior to the operative date of section four hundred and ten A of this act (the Standard Non-forfeiture Law), a non-forfeiture benefit shall be provided in event of default in premium payments after premiums shall have been paid for three years, which shall secure to the owner of the policy a stipulated form of insurance, the net value of which shall be at least equal to the reserve at the date of default on the policy and on any dividend additions thereto, specifying the mortality table and rate of interest adopted for computing such reserves, less a sum not more than two and one-half per centum of the amount insured by the policy and of any existing dividend additions thereto, and less any existing indebtedness to the company on the policy. Such provision shall stipulate that the policy may be surrendered to the company, at its home office, within one month from date of default, for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid, and may stipulate that the company may defer payment for not more than six (6) months after the application therefor is made. This provision shall not be required in term insurance of twenty years or less.

(2) In the case of any policy issued on or after the operative date of section four hundred and ten A of this act (the Standard Non-forfeiture Law), a non-forfeiture benefit and cash surrender value shall be provided in accordance with said section.

(j) A table showing in figures the loan value, if any, and the options, if any, available under the policy, each year, upon default in premium payments, during at least the first twenty years of the policy; and if the proceeds of the policy are payable in installments which are determinable prior to maturity of the policy, a table showing the amount of the guaranteed installments.

(k) A provision that the holder of a policy shall be entitled to have the policy reinstated, upon written application therefor, at any time within three years from the date of default in premium payments, unless the policy has been duly surrendered or the extension period expired, upon the production of evidence of insurability satisfactory to the company, and the payment of all overdue premiums with interest at a rate to be specified in the policy but not exceeding eight per centum per annum, and the payment of any other indebtedness to the company upon said policy with interest at a rate or rates
determined in accordance with section four hundred and ten F, compounded annually. ((k) amended Apr. 8, 1982, P.L.297, No.84)

(l) A provision that when a policy shall become a claim by the death of the insured settlement shall be made upon receipt of due proof of death.

Any of the foregoing provisions, or parts thereof, not applicable to single premium or non-participating policies, shall, to that extent, not be incorporated therein: Provided, however, That the policies of an insurance company organized under the laws of any state or foreign government may contain, when delivered in this Commonwealth, any provision which may be prescribed by laws of the state or government under which the company is organized; and the policies of a life insurance company organized under the laws of this Commonwealth may, when delivered in any other state, territory, or foreign country, contain any provision required by the laws of such state, territory, or foreign country to be contained in policies delivered therein. A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy and shall not preclude the assertion, at any time, of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.

(410 amended July 19, 1951, P.L.1100, No.245)

Section 410A. Standard Nonforfeiture Law for Life Insurance.--(a) In the case of policies issued on or after the operative date of this section, as defined in subsection (j), no policy of life insurance, except as stated in subsection (i), shall be delivered or issued for delivery in this Commonwealth unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Insurance Commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (h):

(1) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(3) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default.

(4) That, if the policy shall have become paid-up by completion of all premium payments or if it is continued under
any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(5) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(6) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to any statute of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(b) (1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a), shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of: (A) the then present value of the adjusted premiums as defined in subsection (d) and subsection (e), corresponding to premiums which would have fallen due on and after such anniversary, and (B) the amount of any indebtedness to the company on the policy.

(2) Provided, however, That for any policy issued on or after the operative date of subsection (e) as defined therein,
which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (1) of this subsection (b) shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in paragraph (1) for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(3) Provided, further, That for any family policy issued on or after the operative date of subsection (e) as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in paragraph (1) of this subsection (b) shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in paragraph (1) for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a), shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(c) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(d) (1) (A) This paragraph (1) shall not apply to policies issued on or after the operative date of subsection (e) as defined therein. Except as provided in subparagraph (C) of this paragraph (1), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (iii) forty percent of the adjusted premium for the first policy year; (iv) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance whichever is less: Provided, however, That in applying the
percentages specified in (iii) and (iv) above, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(B) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy: Provided, however, That in the case of a policy providing a varying amount of insurance issued on the life of a child under ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(C) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to; (a) the adjusted premiums for an otherwise similar policy, issued at the same age, without such term insurance benefits increased during the period for which premiums for such term insurance benefits are payable, by; (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in subparagraphs (A) and (B) of this paragraph (1), except that for the purposes of (ii), (iii) and (iv) of subparagraph (A), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

(D) Except as otherwise provided in paragraphs (2) and (3) of this subsection (d), all adjusted premiums and present values referred to in this section shall, for all policies of ordinary insurance, be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table: Provided, That for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured; and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest not exceeding three and one-half per centum (3-1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits: Provided, however, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred and thirty per centum (130%) of the rates of mortality according to such applicable table: Provided further, That for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Insurance Commissioner.

(2) This paragraph (2) shall not apply to ordinary policies issued on or after the operative date of subsection (e) as
defined therein. In the case of ordinary policies issued on or after the operative date of this paragraph (2) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits: Provided, That such rate of interest shall not exceed three and one-half per centum (3 1/2%) per annum except that a rate of interest not exceeding four per centum (4%) per annum may be used for policies issued on or after June 23, 1976 and prior to July 3, 1980 and a rate of interest not exceeding five and one-half per centum (5 1/2%) per annum or such higher rate of interest as may be approved from time to time by the Insurance Commissioner may be used for policies issued on or after July 3, 1980: Provided, That for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured: And provided further, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table, and that for insurance issued on a substandard basis the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Insurance Commissioner.

After August 14, 1959, any company may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this paragraph (2) after a specified date before January 1, 1966. If a company files such notice, then upon such specified date (which shall be the operative date of this paragraph (2) for such company), this paragraph (2) shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this paragraph (2) for such company shall be January 1, 1966.

(3) This paragraph (3) shall not apply to industrial policies issued on or after the operative date of subsection (e) as defined therein. In the case of industrial policies issued on or after the operative date of this paragraph (3) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits: Provided, That such rate of interest shall not exceed three and one-half per centum (3 1/2%) per annum except that a rate of interest not exceeding four per centum (4%) per annum may be used for policies issued on or after June 23, 1976 and prior to July 3, 1980 and a rate of interest not exceeding five and one-half per centum (5 1/2%) per annum or such higher rate of interest as may be approved from time to time by the Insurance Commissioner may be used for policies issued on or after July 3, 1980: Provided, That in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table; and that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such
other table of mortality as may be specified by the company and approved by the Insurance Commissioner.

After January 25, 1966, any company may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this paragraph (3) after a specified date before January 1, 1970. If a company files such notice, then upon such specified date (which shall be the operative date of this paragraph (3) for such company), this paragraph (3) shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election the operative date of this paragraph (3) for such company shall be January 1, 1970.

(e) (1) This subsection (e) shall apply to all policies issued on or after the operative date of this subsection (e) as defined herein. Except as provided in paragraph (2) of subsection (b) and in paragraph (7) of this subsection (e), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in paragraph (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective
future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where (A) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this subsection (e) shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. Provided, however, that:

(A) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture
interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(C) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(F) ((F) repealed June 30, 2016, P.L.399, No.59).

(G) ((G) repealed June 30, 2016, P.L.399, No.59).

(9) ((9) repealed June 30, 2016, P.L.399, No.59).

(10) Notwithstanding any other provision in this act to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After the effective date of this subsection (e), any company may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection (e) for such company. If a company makes no such election, the operative date of this subsection (e) for such company shall be January 1, 1989.

(f) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsections (a) to (e) herein, then:

(A) The Insurance Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (a) to (e) herein.

(B) The Insurance Commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds.

(C) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by regulations promulgated by the Insurance Commissioner.
(g) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the beginning of the policy year in which the default occurs. All values referred to in subsections (b), (c), (d) and (e) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (b), additional benefits payable (i) in the event of death or dismemberment by accident or accidental means, (ii) in the event of total and permanent disability, (iii) as reversionary annuity or deferred reversionary annuity benefits, (iv) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (v) as term insurance on the life of a child or on the lives of children, provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one and has not become paid-up by reason of the death of a parent of the child and (vi) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(h) (1) This subsection, in addition to all other applicable subsections of this section, shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent (2/10 of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (A) the greater of zero and the basic cash value hereinafter specified and (B) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(2) The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d), whichever is applicable, shall be the same as are the effects specified in subsection (b) or (d), whichever is applicable, on the cash surrender values defined in that subsection.

(3) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (e), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph (3), such percentage:
(A) must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent (2/10 of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(B) must be such that no percentage after the later of the two policy anniversaries specified in the preceding item (A) may apply to fewer than five consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (e), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(4) All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with subsections (a) to (k) of this section. The cash surrender values referred to in this subsection (h) shall include any endowment benefits provided for by the policy.

(5) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment, shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a) to (g). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (i) through (vi) in subsection (g) shall conform with the principles of this subsection (h).

(i) This section shall not apply to any of the following: (1) reinsurance, (2) group insurance, (3) pure endowment, (4) annuity or reversionary annuity contract, (5) term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, (6) term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d) and (e), is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, (7) policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d) and (e), exceeds two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the same policy year, (8) policy which shall be delivered outside this Commonwealth through an agent or other representative of the company issuing the policy. For purposes of determining the applicability of this section, the age at
expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(j) After the effective date of this act, any company may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this section after a specified date. After the filing of such notice, then upon such specified date (which shall be the operative date for such company), this section shall become operative with respect to the policies and contracts thereafter issued by such company: Provided, however, That the operative date for every life insurance company, except a limited life insurance company, shall not in any event be later than January first, nineteen hundred and forty-eight.

(k) This section shall be known as the Standard Nonforfeiture Law for Life Insurance.

(410A amended Feb. 28, 1982, P.L.95, No.37)

Section 410B. Uniform Provisions for Contracts of Annuities and Pure Endowment Contracts.--No annuity or pure endowment contract shall be delivered in this Commonwealth, except policies of industrial insurance where the premiums are payable monthly or oftener, and except in the case of a reversionary annuity, otherwise called a survivorship annuity, or an annuity contracted by an employer in behalf of his employes, unless it contains in substance the following provisions: (Par. amended July 19, 1951, P.L.1100, No.245)

(a) A provision that there shall be a period of grace, either of thirty days or of one month, within which any stipulated payment to the company, falling due after the first year, may be made, subject, at the option of the company, to an interest charge thereon at a rate to be specified in the contract, but not exceeding eight per centum per annum, for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force, but in case a claim arises under the contract on account of death during the said period of grace before the overdue payment to the company or the deferred payments of the current year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement; if the contract contains a loan provision, the rate of interest for contracts issued prior to the effective date of section four hundred and ten F may not exceed eight per centum per annum; ((a) amended Apr. 8, 1982, P.L.297, No.84)

(b) If statements, other than those relating to age and identity, are required as a condition of issuing the contract, a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or each of the persons as to whom such statements are required for a period of two years from its date of issue, except where stipulated payments to the company have not been made, and except for violation of the conditions of the contract relating to military or naval service in time of war, and, at the option of the company, provisions relative to benefits in the event of total and permanent disability, and provisions which grant insurance specifically against death by accident may also be excepted;

(c) A provision that such contract shall constitute the entire contract between the parties, but if the company desires to make the application a part of the contract, it may do so, provided a copy of such application shall be indorsed upon or attached to such contract when issued, and in such case, such contract shall contain a provision that it, together with the
application therefor, shall constitute the entire contract between the parties;

(d) A provision that, if the age of the person or persons upon whose life or lives the contract is based, or of any of them, has been misstated, the amount payable under the contract shall be such as the stipulated payments to the company would have purchased at the correct age or ages. Any overpayment or overpayments by the company on account of misstatement of age shall, with interest thereon at a rate to be specified in the contract, but not exceeding six per centum per annum, to be charged against the current or next succeeding payment or payments to be made by the company under the contract;

(e) If the contract is participating, a provision that the divisible surplus shall be apportioned annually, and dividends shall be payable in cash or shall be applicable to any stipulated payment or payments to the company under the contract;

(f) A provision specifying the options available upon cessation of payment of considerations under the contract.

(1) In the case of contracts issued prior to the effective date of this amendatory act, such provision shall specify that, if the contract, after having been in force for three full years, shall by its terms lapse or become forfeited because any stipulated payment to the company shall not have been made, the reserve on such contract, computed according to the standard adopted by said company in accordance with section three hundred and one of this act shall, after deducting one-fifth of the said entire reserve and any indebtedness to the company under the contract, be applied as a net single payment according to said standard for the purchase of a paid up annuity or pure endowment contract, which may be nonparticipating and which shall be payable by the company under the same terms and conditions, except as to amount of the original contract. A company may provide, in lieu of said paid up values, for a paid up annuity or pure endowment contract in an amount bearing the same proportion to the original annuity or pure endowment contract as the number of stipulated payments, which shall have been made to the company, shall bear to the total number of stipulated payments required to be made to the company under the contract, and if there be any indebtedness to the company under the contract, the amount of such paid up annuity or pure endowment shall be reduced by an amount bearing the same proportion to such paid up annuity or pure endowment as such indebtedness bears to the reserve on such paid up annuity or pure endowment, computed according to the standard adopted by said company in accordance with section three hundred and one of an act, approved the seventeenth day of May, one thousand nine hundred and twenty-one (Pamphlet Laws, seven hundred and eighty-nine), as amended;

(2) In the case of contracts issued on or after the effective date of this amendatory act, such provisions shall be in accordance with section 410C.

((f) amended July 3, 1980, P.L.351, No.89)

(g) A provision that the contract may be reinstated at any time within one year from the date of default in making stipulated payments to the company, provided that all overdue stipulated payments shall be made or paid with interest thereon at a rate to be specified in the contract, but not exceeding eight per centum per annum, and any indebtedness to the company on the contract shall be paid with interest at a rate or rates determined in accordance with section four hundred and ten F, compounded annually. In cases where applicable, a company may
also include a requirement of evidence of insurability satisfactory to the company.

No contract for a reversionary annuity shall be so issued or delivered unless it contains in substance the following provisions:

1. Provisions (a), (b), (c), and (e) of this section, except that under provision (a) the company may, at its option, provide for an equitable reduction of the amount of the annuity payments in settlement, or an overdue or deferred payments in lieu of providing for a deduction of such payments from any amount payable upon a settlement under the contract.

2. A provision that, if the age of any of the persons upon whose lives the contract is based, has been misstated, the amount payable under the contract shall be such as the stipulated payments to the company would have purchased at the correct ages.

3. A provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the company upon production of evidence of insurability satisfactory to the company, provided that all overdue payments shall be made or paid with interest thereon at a rate to be specified in the contract, but not exceeding eight per centum per annum, any indebtedness to the company shall be paid with interest thereon at a rate or rates determined in accordance with section four hundred and ten F, compounded annually.

Any of the foregoing provisions, or portions thereof, not applicable to nonparticipating contracts nor to contracts for which a single stipulated payment to the company is made, shall to that extent not be incorporated therein, and any such contract may be delivered in this Commonwealth, which, in the opinion of the Insurance Commissioner, contains provisions, on any one or more of the several foregoing requirements, more favorable to the holder of the contract than hereinbefore required.

Nothing herein contained shall be construed to prevent a life insurance corporation, which issues life insurance on a participating basis, from issuing annuities, reversionary annuities, or pure endowments on a nonparticipating basis.

Any such contract or any application, endorsement or rider form used in connection therewith, issued in violation of this section shall, nevertheless, be held valid, but shall be construed as provided in this section, and when any provision in such contract, application, endorsement, or rider is in conflict with any provision of this section or with any other statutory provision, the rights, duties, and obligations of the company, of the holder of the contract, and of the beneficiary or annuity thereunder shall be governed by the provisions of this section. The provisions of this section shall not apply to contracts of reinsurance, nor to contracts for deferred annuities or reversionary annuities included in life insurance policies.

((g) amended Apr. 8, 1982, P.L.297, No.84)
(410B added July 17, 1935, P.L.1116, No.358)

Section 410C. Standard Nonforfeiture Law for Individual Deferred Annuities.--(a) This section shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

(b) This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or an employee organization, or by both, other than a plan providing individual
retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this State through an agent or other representative of the company issuing the contract.

(c) In the case of contracts issued on or after the exact date of this section as defined in subsection (l) no contract of annuity, except as stated in subsection (b) shall be delivered or issued for delivery in this State unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract.

(1) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (e), (f), (g), (h) and (j).

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (e), (f), (h) and (j). The company shall reserve the right to defer the payment of such cash surrender benefit for a period of six (6) months after demand therefor with surrender of the contract.

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract. Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars ($20) monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(c.1) In the case of contracts issued on or after January 1, 2006, and in the case of any class of annuity contracts issued before January 1, 2006, as to which the issuing company has filed with the Insurance Department a notice of election of the applicability of this section, no contract of annuity, except as provided under subsection (b), shall be delivered or issued for delivery in this Commonwealth unless it contains in
substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (e), (f), (g), (h) and (j);

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (e), (f), (h) and (j). The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefore with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract. Notwithstanding the requirements of this subsection, a deferred annuity contract may provide that, if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than twenty dollars ($20) monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

(d) The minimum values as specified in subsections (e), (f), (g), (h) and (j), of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(1) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of three per centum (3%) per annum of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of:

(A) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three per centum (3%) per annum; and
(B) the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars ($30) and less a collection charge of one dollar and twenty-five cents ($1.25) per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five per centum (65%) of the net considerations for the first contract year and eighty-seven and one-half per centum (87.5%) of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five per centum (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five per centum (65%).

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with two exceptions:

(A) The portion of the net consideration for the first contract year to be accumulated shall be sum of sixty-five per centum (65%) of the net consideration for the first contract year plus twenty-two and one-half per centum (22.5%) of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

(B) The annual contract charge shall be the lesser of (i) thirty dollars ($30) or (ii) ten per centum (10%) of the gross annual considerations.

(3) With respect to contracts providing for a single consideration, minimum amount shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety per centum (90%) and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars ($75).

(d.1) In the case of contracts issued on or after January 1, 2006, and in the case of any class of annuity contracts issued before January 1, 2006, as to which the issuing company has filed with the Insurance Department a notice of election of the applicability of this section, the minimum values as specified in subsections (e), (f), (g), (h) and (j) of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts set forth in this section.

(1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in paragraph (3) of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of:
(A) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in paragraph (3); and
(B) An annual contract charge of up to fifty dollars ($50), accumulated at rates of interest as indicated in paragraph (3);
(C) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in paragraph (3); and
(D) The amount of any indebtedness to the company on the contract, including interest due and accrued.
(2) The net consideration for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half per centum (87.5%) of the gross consideration credited to the contract during that contract year.
(3) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three per centum (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
(A) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one per centum (.05%) specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under subparagraph (D) of paragraph (3);
(B) Reduced by one hundred twenty-five (125) basis points;
(C) Where the resulting interest rate is not less than one per centum (1%); and
(D) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.
(4) During the period or term that a contract provides substantive participation in an equity index benefit, it may increase the reduction described in paragraph (3)(B) by up to an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.
(5) The commissioner may adopt rules to implement the provisions of paragraph (4) and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.
(e) Any paid-up annuity benefit available under a contract shall be such that its present value on the date of annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up benefits guaranteed in the contract.
(f) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall
not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one per centum (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(g) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to that maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amount credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of the paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(h) For the purpose of determining the benefits calculated under subsections (f) and (g) in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

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

(j) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

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

(1) After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before the second anniversary of the effective date of this section. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to annuity contracts, thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be the second anniversary of the effective date of this section.

(m) Notwithstanding the provisions of subsection (d) and except as provided under subsections (c.1) and (d.1), for any contract issued on or after July 1, 2002, and before January 1, 2006, the interest rate at which minimum nonforfeiture amounts, partial withdrawals and partial surrenders shall be accumulated shall be one and one-half per centum (1.5%) per annum.

(410C amended Nov. 30, 2004, P.L.1690, No.216)

Section 410D. Notice of Policyholder's Right to Examine Life and Endowment Insurance Policies.--(a) (1) Except as provided in paragraphs (2) and (3), individual fixed dollar life insurance or endowment insurance policies shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least ten (10) days of its delivery and to have the premium paid refunded if after examination of the policy, the policyholder is not satisfied with it for any reason.

(2) Individual fixed dollar life insurance or endowment insurance policies which are offered as replacements for an existing life insurance policy or annuity contract with the same insurer or insurer group shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least forty-five (45) days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied with it for any reason.

(3) Individual fixed dollar life insurance or endowment insurance policies which are offered as replacements for an existing life insurance policy or annuity contract with an
insurer or insurer group other than the one which issued the original policy or contract shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least twenty (20) days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied with it for any reason.

(b) (1) Except as provided in paragraphs (2) and (3), individual variable life policies shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least ten (10) days of its delivery if after examination of the policy the policyholder is not satisfied with it for any reason, and the notice shall state that in such event the insurer shall pay to the policyholder an amount equal to any of the following:

(i) the stipulated payment or premium paid;

(ii) the difference between:

(A) the premiums paid, including any policy fees or other charges and the amounts, if any, allocated to any separate accounts under the policy; and

(B) the cash value of the policy or, if the policy does not have a cash value, the reserve for the policy on the date of surrender attributable to the amounts so allocated; or

(iii) the greater of subparagraph (i) or (ii).

(2) Individual variable life insurance policies which are offered as replacements for an existing life insurance policy or annuity contract with the same insurer or insurer group shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least forty-five (45) days of its delivery if after examination of the policy the policyholder is not satisfied with it for any reason, and the notice shall state that in such event the insurer shall pay to the policyholder an amount equal to any of the following:

(i) the stipulated payment or premium paid;

(ii) the difference between:

(A) the premiums paid, including any policy fees or other charges and the amounts, if any, allocated to any separate accounts under the policy; and

(B) the cash value of the policy or, if the policy does not have a cash value, the reserve for the policy on the date of surrender attributable to the amounts so allocated; or

(iii) the greater of subparagraph (i) or (ii).

(3) Individual variable life insurance policies which are offered as replacements for an existing life insurance policy or annuity contract with an insurer or insurer group other than the one which issued the original policy or contract shall not be delivered in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least twenty (20) days of its delivery if after examination of the policy the policyholder is not satisfied with it for any reason, and the notice shall state that in such event the insurer shall pay to the policyholder an amount equal to any of the following:
(i) the stipulated payment or premium paid;
(ii) the difference between:
   (A) the premiums paid, including any policy fees or other
       charges and the amounts, if any, allocated to any separate
       accounts under the policy; and
   (B) the cash value of the policy or, if the policy does not
       have a cash value, the reserve for the policy on the date of
       surrender attributable to the amounts so allocated; or
(iii) the greater of subparagraph (i) or (ii).


Section 410E. Notice of Contractholder's Right to Examine
Annuity or Pure Endowment Contracts.--(a) (1) Except as
provided in paragraphs (2) and (3), individual fixed dollar
annuity or pure endowment contracts shall not be entered into
in the Commonwealth of Pennsylvania unless they shall have
prominently printed on the first page of such contract or
attached thereto a notice stating in substance that the
contractholder shall be permitted to return the contract within
at least ten (10) days of its delivery and to have the
stipulated payment or premium paid refunded if after examination
of the contract, the contractholder is not satisfied with it
for any reason.

(2) Individual fixed dollar annuity contracts which are
offered as replacements for an existing annuity contract or
life insurance policy with the same insurer or insurer group
shall not be entered into in the Commonwealth of Pennsylvania
unless they shall have prominently printed on the first page
of such contract or attached thereto a notice stating in
substance that the contractholder shall be permitted to return
the contract within at least forty-five (45) days of its
delivery and to have the premium refunded if after examination
of the contract the contractholder is not satisfied with it
for any reason.

(3) Individual fixed dollar annuity contracts which are
offered as replacements for an existing annuity contract or
life insurance policy with an insurer or insurer group other
than the one which issued the original contract or policy shall
not be entered into in the Commonwealth of Pennsylvania
unless they shall have prominently printed on the first page
of such contract or attached thereto a notice stating in
substance that the contractholder shall be permitted to return
the contract within at least twenty (20) days of its delivery and to have
the premium refunded if after examination of the contract the
contractholder is not satisfied with it for any reason.

(b) (1) Except as provided in paragraphs (2) and (3),
individual variable annuity contracts shall not be entered into
in the Commonwealth of Pennsylvania unless they shall have
prominently printed on the first page of such contract or
attached thereto a notice stating in substance that the
contractholder shall be permitted to return the contract within
at least ten (10) days of its delivery if after examination of
the contract the contractholder is not satisfied with it for
any reason. The notice shall state that in such event the
insurer shall pay to the contractholder an amount equal to any
of the following:
   (i) the stipulated payment or premiums paid;
   (ii) the difference between:
(A) the premiums paid, including any contract fees or other
    charges and the amounts, if any, allocated to any separate
    accounts under the contract; and
(B) the cash value of the contract or, if the contract does not have a cash value, the reserve for the contract on the date of surrender attributable to the amounts so allocated; or

(iii) the greater of subparagraphs (i) or (ii).

(2) Individual variable annuity contracts which are offered as replacements for an existing annuity contract or life insurance policy with the same insurer or insurer group shall not be entered into in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such contract or attached thereto a notice stating in substance that the contractholder shall be permitted to return the contract within at least forty-five (45) days of its delivery if after examination of the contract the contractholder is not satisfied with it for any reason, and in such event the notice shall state that in such event the insurer shall pay to the contractholder an amount equal to any of the following:

(i) the stipulated payment or premium paid;

(ii) the difference between:

(A) the premiums paid, including any contract fees or other charges and the amounts, if any, allocated to any separate accounts under the contract; and

(B) the cash value of the contract or, if the contract does not have a cash value, the reserve for the contract on the date of surrender attributable to the amounts so allocated; or

(iii) the greater of subparagraph (i) or (ii).

(3) Individual variable annuity contracts which are offered as replacements for an existing annuity contract or life insurance policy with an insurer or insurer group other than the one which issued the original contract or policy shall not be entered into in the Commonwealth of Pennsylvania unless they shall have prominently printed on the first page of such contract or attached thereto a notice stating in substance that the contractholder shall be permitted to return the contract within at least twenty (20) days of its delivery if after examination of the contract the contractholder is not satisfied with it for any reason, and in such event the notice shall state that in such event the insurer shall pay to the contractholder an amount equal to any of the following:

(i) the stipulated payment or premium paid;

(ii) the difference between:

(A) the premiums paid, including any contract fees or other charges and the amounts, if any, allocated to any separate accounts under the contract; and

(B) the cash value of the contract or, if the contract does not have a cash value, the reserve for the contract on the date of surrender attributable to the amounts so allocated; or

(iii) the greater of subparagraph (i) or (ii).


Section 410F. Policy Loan Interest Rate Law.--(a) The purpose of this section is to permit and set guidelines for companies to include in life insurance policies and annuity contracts, if such contracts contain a loan provision, issued after the effective date of this act a provision for periodic adjustment of policy loan interest rates.

(b) For purposes of this section, the "Published Monthly Average" means:

(1) Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor thereto; or

(2) In the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published, a
substantially similar average, established by regulation issued by the Insurance Commissioner.

(c) (1) Policies issued on or after the effective date of this act shall provide for policy loan interest rates as follows:
   (i) a provision permitting a maximum interest rate of not more than eight per centum per annum; or
   (ii) a provision permitting an adjustable maximum interest rate established from time to time by the company as permitted by law.

(2) The rate of interest charged on a policy loan made under subsection (c)(1)(ii) shall not exceed the higher of the following:
   (i) the Published Monthly Average for the calendar month ending two months before the date on which the rate is determined; or
   (ii) the rate used to compute the cash surrender values under the policy during the applicable period plus one per centum per annum.

(3) If the maximum rate of interest is determined pursuant to subsection (c)(1)(ii), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(4) The maximum rate for each policy must be determined at regular intervals at least once every twelve months, but not more frequently than once in any three-month period. At the intervals specified in the policy:
   (i) The rate being charged may be increased whenever such increase as determined under subsection (c)(2) would increase that rate by one-half per centum or more per annum.
   (ii) The rate being charged must be reduced whenever such reduction as determined under subsection (c)(2) would decrease that rate by one-half per centum or more per annum.

(5) The company shall:
   (i) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;
   (ii) notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in subsection (c)(5)(iii) below;
   (iii) send to policyholders with loans reasonable advance notice of any increase in the rate; and
   (iv) include in the notices required above the substance of the pertinent provisions of subsections (c)(1) and (3).

(6) The loan value of the policy shall be determined in accordance with subsection (h) of section four hundred and ten but no policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the company shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(7) The substance of the pertinent provisions of subsection (c)(1) and (3) shall be set forth in the policies to which they apply.

(8) For purposes of this section:
   (i) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.
(ii) The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the company as they fell due.

(iii) The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the company.

(iv) The term "policy" include certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(9) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

(d) The provisions of this section shall not apply to any insurance contract issued before the effective date of this act unless the policyholder agrees in writing to the applicability of such provisions.

(410F added Apr. 8, 1982, P.L.297, No.84)

Section 411. Prohibited Policy Provisions.--No policy of life insurance shall be delivered in this Commonwealth, except policies of industrial insurance where the premiums are payable monthly or oftener, if it contain any of the following provisions: (Par. amended July 19, 1951, P.L.1100, No.245)

(a) Any provision for forfeiture of the policy for failure to repay any loan on the policy or to pay interest on any such loan, while the total indebtedness on the policy is less than the cash value thereof. In ascertaining the indebtedness due upon the policy loan, the interest, if not paid when due, shall be added to the principal of such loan, and shall bear interest at the rate specified in the note or loan agreement.

(b) Any provision limiting the time within which any action at law or equity may be commenced to less than two years after the cause of action shall accrue.

(c) Any provision by which the policy shall purport to be issued or to take effect more than six months before the original application for the insurance was made. ((c) amended July 19, 1951, P.L.1100, No.245)

(d) Any provision for a mode of settlement at maturity of less value than the amount insured on the face of the policy, plus dividend additions, if any, less the indebtedness to the company on the policy, and less any premiums that may by the terms of the policy be deducted.

(411 amended June 4, 1937, P.L.1634, No.338)

Section 411A. Effect of Medical Examination and Waiver Thereof.--In any case where the medical examiner, or physician acting as such, or the agent of the insurer recording the answers of the applicant where a medical examination is waived, of any insurance company doing business in this State, shall issue a certificate of health, or declare the applicant a fit subject for insurance, or so report to the company or its agent under the rules and regulations of the company, it shall thereby be estopped from setting up in defense of the action on the policy or certificate issued to the insured, that the insured was not in the condition of health required by the policy or certificate or by the company issuing the same at the time of the medical examination, or the recording of the answers of the applicant where a medical examination is waived, unless the same was procured by or through the fraud, deceit, or misrepresentation of or on behalf of the insured.

(411A added July 19, 1935, P.L.1319, No.413)

Section 411B. Payment of Benefits.--(a) Except as set forth in subsection (b), life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to
the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured and the death benefits are not paid within thirty days after satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

(b) Notwithstanding section 6 of the act of May 11, 1949 (P.L.1210, No.367), referred to as the Group Life Insurance Policy Law, this section shall apply to all life insurance policies except variable insurance policies.

(c) The term "left on deposit" shall mean a specific settlement option provided within the life insurance policy under which the death benefit proceeds are retained by the insurer for the beneficiary and are credited with a specific rate of interest.

(411B added Dec. 20, 2000, P.L.967, No.132)

Section 412. Application for Insurance; Insurable Interest.--No policy of life insurance shall be delivered in this Commonwealth except upon the application of the person insured. A person liable for the support of a child may take out a policy of insurance on such child; and persons, copartnerships, associations, corporations, and the trustee of a trust established by a person, copartnership, association or corporation providing benefits to its officers, directors, principals, partners or employes may insure the lives and health of officers, directors, principals, partners, and employes, without the signing of a personal application as hereinafter required: Provided, That such persons, copartnerships, associations, corporations and the trustee of a trust established by a person, copartnership, association or corporation shall notify such officers, directors, principals, partners and employes in writing of the intent to purchase a policy of life insurance insuring the lives of such officers, directors, principals, partners or employes and obtain the prior written consent of such officers, directors, principals, partners or employes. Any person may insure his own life for the benefit of any person, copartnership, association, corporation, or trustee of a trust established by a person, copartnership, association or corporation, but no person shall cause to be insured the life of another, unless the beneficiary named in such policy or agreement of life insurance, whether himself or a third person, has an insurable interest in the life of the insured. If a policy of life insurance has been issued in conformity with this section, no transfer of such policy or any interest thereunder shall be invalid by reason of a lack of insurable interest of the transferee in the life of the insured or the payment of premiums thereafter by the transferee. The term "insurable interest" is defined as meaning, in the case of persons related by blood or law, an interest engendered by love and affection, and, in the case of other persons, a lawful economic interest in having the life of the insured continue, as distinguished from an interest which would arise only by the death of the insured. A charitable organization that meets the requirements of section 501(c)(3) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 501(c)(3)), as amended, may own or purchase life
insurance on an insured who consents to the ownership or purchase of that insurance.

(412 amended Dec. 23, 2003, P.L.358, No.50)

Section 413. Proceeds of Annuities and Policies Retained at Maturity Part of General Corporate Funds.--Whenever under the terms of any annuity or policy of life insurance, or under any written agreement supplemental thereto, issued by any stock or mutual life insurance company incorporated by and doing business in this State, the proceeds are retained by such company at maturity or otherwise, such company shall not be required to segregate such funds, but may hold such funds as part of its general corporate funds.

Section 414. Misrepresentation, Et Cetera, for the Purpose of Securing Insurance; Penalty.--Any agent of a stock or mutual life insurance company, or any physician or other person whatsoever, who shall knowingly make, or be concerned or interested in making, any misrepresentation or false statement for the purpose of securing, from any stock or mutual life insurance company, a policy of insurance upon his own life or the life of any other person, shall be guilty of a misdemeanor, and, upon conviction thereof, be fined not exceeding one thousand dollars, or undergo imprisonment not exceeding one year, or both; or, upon satisfactory evidence of the violation of this section by any agent or solicitor of any insurance company, association, or exchange, or by any insurance broker or excess insurance broker, the Insurance Commissioner may, in his discretion, take, against the offending party, any one or more of the following courses of action: (1) Suspend or revoke the license of such offending solicitor or agent, insurance broker, or excess insurance broker; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such offending agent, solicitor, broker, or excess insurance broker; (3) impose a penalty of not more than one thousand dollars for each act of violation of this section.


Section 415. Definition of Group Life Insurance.--(415 repealed May 11, 1949, P.L.1210, No.367)


Section 417. Voting Power Under Policies of Group Life Insurance.--In every group policy issued by a domestic life insurance company the employer shall be deemed to be the policyholder for all purposes within the meaning of this act, and, if entitled to vote at a meeting of the company, shall be entitled to one vote thereat.

(417 added Apr. 26, 1929, P.L.785, No.336)

Section 418. Exemption from Execution.--(418 repealed Apr. 28, 1978, P.L.202, No.53)

Section 419. Certain Companies Heretofore Organized May Come within Provisions of Act.--Every company incorporated or reincorporated under the act of April twenty-eighth, one thousand nine hundred and three (Pamphlet Laws, three hundred twenty-nine), entitled "An act to provide for the incorporation and regulation of corporations for the purpose of making insurance upon the health of individuals, and against personal injury and disablement and death therein; limiting the amount for which such corporations may issue policies, and providing the manner in which certain existing corporations may become reincorporated under this act," or under the act of April twentieth, one thousand nine hundred twenty-seven (Pamphlet Laws, three hundred seventeen), entitled "An act authorizing
certain existing beneficial or protective societies, heretofore
incorporated, to reincorporate for the purpose of making
insurance upon the health of individuals and against personal
injury and disablement and death; regulating such corporations
and limiting the amount for which corporations may issue
policies; and imposing a tax on gross premiums of companies
reincorporated under the provisions of this act," or under the
act of June twenty-fourth, one thousand nine hundred thirty-nine
(Pamphlet Laws, six hundred eighty-six), entitled "An act
authorizing certain existing beneficial or protective societies,
heretofore incorporated, to reincorporate as limited life
insurance companies for the purpose of making insurance upon
the health of individuals and against personal injury and
disablement and death; regulating such corporations and limiting
the amount for which such corporations may issue policies," or
under any subsequent act, authorizing certain existing
incorporated beneficial or protective societies to
reincorporate, or to merge and reincorporate as limited life
insurance companies, or under the act of July 15, 1957 (P.L.
929), entitled "An act authorizing the incorporation of limited
life insurance companies for the purpose of issuing insurance
upon the health of individuals and against personal injury
and disablement and death, including endowment insurance; regulating
such companies and limiting the amounts for which such companies
may issue policies," may, notwithstanding any limitation to the
contrary, established by any act of Assembly or by the
provisions of its charter, issue policies insuring the lives
of persons, and every insurance appertaining thereto, may grant
and dispose of annuities, and may insure against personal
injury, disablement or death resulting from traveling or general
accidents, and against disablement resulting from sickness, and
every insurance appertaining thereto, as specified in
subdivision (a) clauses one (1) and two (2) of section two
hundred and two (202) of this act, if such company has and
maintains the capital and surplus required of stock and mutual
insurers under sections 206 and 206.2 of this act.
(419 amended Dec. 18, 1992, P.L.1519, No.178)

(b) PROVISIONS RELATING TO STOCK COMPANIES.

Section 420. Exchange, Alteration and Conversion of
Policies.--Any life insurance company may, at the request of a
policyholder, exchange, alter or convert any policy of life or
endowment insurance, or annuity policy contract, or any other
policy benefits additional thereto issued by it, for or into
any policy which conforms with the laws in force on the date
of the original policy, if the rewritten policy is, by its
terms, made effective as of such date, or which conforms with
the laws in force on a subsequent date as of which the rewritten
policy is by its terms made effective. If the rewritten policy
is made effective as of a date earlier than the date on which
the exchange, alteration or conversion occurs, (a) the rewritten
policy, if evidence of insurability is required in conjunction
with an exchange, alteration or conversion to a policy on a
plan requiring a lower premium rate or to a policy to which
benefits or features are added differing from those in the
original policy, may provide that the date on which the
exchange, alteration or conversion occurs shall be used in
determining the applicability of an incontestability clause in
the rewritten policy to the right of the company to contest
such exchange, alteration or conversion or in determining the
applicability of a clause in the rewritten policy limiting
liability in the event of suicide of the insured, and (b) the amount of insurance under said rewritten policy shall not exceed the amount of insurance under said original policy, or the amount of insurance which the premium paid for the original policy would have purchased if the rewritten policy had been originally applied for, whichever amount is the greater. Nothing contained in section three hundred and forty-six, or in clause (c) of section four hundred and eleven, of this act shall be construed as prohibiting any such exchange, alteration, or conversion of policies as provided by this section.

(420 amended July 19, 1951, P.L.1100, No.245)

Section 420A. Minors May Enter into Insurance or Annuity Contracts and Have Full Rights, Powers and Privileges Thereunder and Minors Empowered to Give Valid Acquittance and Discharge for Insurance Benefits.--(420A repealed May 5, 1982, P.L.373, No.107)

Section 420B. Definition of Industrial Insurance.--Industrial life or industrial endowment insurance is hereby declared to be that form of insurance, either
(1) Under which premiums are payable weekly, or
(2) Under which premiums are payable monthly or oftener, but other than weekly, if the face amount of insurance provided in the policy is less than one thousand dollars, and the words "Industrial Policy" are printed upon the face of the policy. In all such policies, as above defined in subdivision one (1), the words "industrial policy" must be printed upon the policy as a part of the descriptive matter.
(420B added May 21, 1937, P.L.769, No.209)

Section 420C. Uniform Industrial Policy Provisions.--No policy of industrial insurance shall be delivered in this Commonwealth, unless the same shall contain in substance the following provisions:
(a) A provision that the insured is entitled to a grace of four (4) weeks within which the payment of any premium after the first may be made, except that where premiums are payable monthly the insured shall be entitled to a grace of one month or 30 days. During such period of grace the policy shall continue in full force, but in case the policy becomes a claim during said grace period, before the overdue premiums are paid, the amount of overdue premiums may be deducted in any settlement under the policy.
(b) A provision that the policy shall constitute the entire contract between the parties; but if the company desires to make the application a part of the contract, it may do so provided a copy of such application shall be endorsed upon or attached to the policy when issued, and in such case the policy shall contain a provision that the policy and the application therefor shall constitute the entire contract between the parties.
(c) A provision that the policy shall be incontestable after it has been in force, during the life-time of the insured, two years from its date of issue, except for non-payment of premium, and that, at the option of the company, provisions relating to disability benefits and those granting additional insurance specifically against death by accident or accidental means may also be excepted.
(d) A provision that, if the age of the insured or of any other person whose age is considered in determining the premium has been misstated, the amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.
(e) A provision that the policy shall participate in the surplus of the company, and that the company will annually determine the portion of any divisible surplus accruing on the policy, and indicating the conditions under which the company shall apportion such dividends to the policyholder or the party entitled thereto.

(f) A provision for a non-forfeiture benefit and cash surrender value.

(1) In the case of any policy issued prior to the operative date of section four hundred and ten A of this act (the Standard Non-forfeiture Law), a non-forfeiture benefit shall be available in event of default in premium payments, after premiums have been paid for three full years, and shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which stipulated form of insurance shall not be less than the reserve on the policy (exclusive of reserves, if any, for provisions relating to benefits in the event of specific types of disability, or provisions granting additional insurance specifically against death by accident, and for provisions granting other benefits in addition to life insurance) at the end of the last completed quarter of the policy year for which premiums have been paid, and on any dividend additions thereto, if any, (the policy to specify the mortality table and rate of interest and also the method of valuation, if other than net level premium, adopted for computing such reserve) less a specified maximum percentage (not more than two and one-half) of the maximum face amount insured by the policy and of dividend additions thereto, if any, and less any existing indebtedness to the company on or secured by the policy: Provided, however, That the said percentage or other rule of calculation so stated as to permit determination of the value shall be specified for each year for which required values are not included in the policy: And provided, A company may, in lieu of the provision herein permitted for the deduction from the reserve of a sum not more than two and one-half per centum of the maximum face amount insured by the policy and of any dividend additions thereto, insert in the policy a provision that a deduction of one-fifth of said reserve may be made or said two and one-half per centum of the maximum face amount insured or one-fifth of said reserve at the option of the company: Provided further, That after premiums have been paid for five full years, the policy may be surrendered to the company at its home office within four weeks of the due date of the defaulted premium for a specific cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid: And provided further, That the company may defer payment of such cash value for not more than six months after application therefor is made. In the event that such cash or other non-forfeiture value is not requested within the required period, it shall be provided that a stipulated form of insurance shall automatically become effective.

(2) In the case of any policy issued on or after the operative date of section four hundred and ten A of this act (the Standard Non-forfeiture Law), a non-forfeiture benefit and cash surrender value shall be provided in accordance with said section.

(g) A table showing, in figures, the non-forfeiture options available under the policy at the end of each year upon default in premium payments during the premium payment period, but not to exceed the first twenty (20) years of the policy, and
providing that the company will furnish upon request an extension of such table beyond the years shown in the policy.

(h) A provision that the policy, if not surrendered for its cash value or if the period of extended insurance has not expired, may be reinstated, upon written application therefor, within one year from the date of default in payment of premiums, upon payment of all overdue premiums and, at the option of the company, interest thereon at a rate not to exceed eight per centum per annum and the payment or reinstatement of any other indebtedness to the company upon said policy, and, at the option of the company, interest thereon at a rate or rates determined in accordance with section four hundred and ten F, compounded annually, and upon the presentation of evidence satisfactory to the company of the insurability of the insured. ((h) amended Apr. 8, 1982, P.L.297, No.84)

(i) A provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death.

(j) A form number and title on the face of the policy clearly and correctly describing its form.

Any such policy may be delivered in this Commonwealth which, in the opinion of the Insurance Commissioner, contains provisions on any one or more of the several foregoing requirements more favorable to the policyholder than hereinbefore required. The policies of an insurance company organized under the laws of any other state or foreign government may contain, when delivered in this Commonwealth, any provision which may be prescribed by the laws of the state or government under which the company is organized not contrary to the provisions heretofore prescribed, and the policies of a life insurance company organized under the laws of this Commonwealth, when delivered in any other state, territory or foreign country, may contain any provision required by the laws of such state, territory or foreign country to be contained in the policies delivered therein.

Any of the foregoing provisions, or parts thereof, not applicable to non-participating policies shall, to that extent, not be incorporated therein and the provisions of this section shall not apply to policies issued or granted pursuant to the non-forfeiture provisions prescribed in clause (f) of this section. A clause in any policy of industrial life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion, at any time, of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.

(420C amended July 19, 1951, P.L.1100, No.245)

Section 420D. Prohibited Industrial Policy Provisions.--No policy of industrial life or industrial endowment insurance shall be delivered in this Commonwealth, if it contains any of the following provisions: (Par. amended July 19, 1951, P.L.1100, No.245)

(a) A provision limiting the time within which any action at law or in equity may be commenced to less than two years after the cause of action shall accrue.

(b) A provision by which the settlement on the maturity of any policy shall be of less value than the amount promised on the face of the policy plus dividend additions, if any, less any indebtedness to the company on or secured by the policy, and less any premium that may, by the terms of the policy, be
deducted, payments to be made in accordance with the terms of the policy.

(c) A provision to the effect that the agent soliciting the insurance is the agent of the person insured under said policy, or making the acts or representations of such agent binding upon the person so insured under said policy.

(d) A provision by which the company may pay the proceeds of the policy at the death of the insured to any person other than the beneficiary designated in the policy, except that the policy may provide that, if the beneficiary does not within the period stated therein, which shall not be less than thirty (30) days after the death of the insured, submit proof of claim in the manner and form required by this policy, or if there is no beneficiary designated in the policy, other than the estate of the insured, or if the beneficiary is a minor or is not legally qualified to give a valid release, or dies before the insured, then, in any such case, the company may pay the proceeds of the policy to the executor or administrator of the insured, or to any relative by blood or connection by marriage of the insured appearing to the company to be equitably entitled to the same.

(e) A provision by which the company may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same company.

(420D added May 21, 1937, P.L.769, No.209)

Section 420E. Notice of Policyholder's Right to Examine Industrial Life or Industrial Endowment Insurance Policies.—No policy of industrial life or industrial endowment insurance shall be delivered in the Commonwealth of Pennsylvania after January 1, 1982 unless it shall have prominently printed on the first page of such policy or attached thereto a notice stating in substance that the policyholder shall be permitted to return the policy within at least ten (10) days of its delivery and to have the premium paid refunded if after examination of the policy, the policyholder is not satisfied with it for any reason. If a policyholder pursuant to such notice returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

(420E added Nov. 5, 1981, P.L.325, No.116)

Section 421. Dividends.—(421 repealed Feb. 17, 1994, P.L.92, No.9)

(c) PROVISIONS RELATING TO MUTUAL COMPANIES.

Section 426. Obligations for Guarantee Capital Assessments.—Every person subscribing to the guarantee capital of any mutual life insurance company, organized under this act, shall give to said company his note or obligation, in such form as the by-laws of the company may prescribe, for the unpaid moiety of the guarantee capital so subscribed, which note or obligation shall be liable to assessment or assessments, from time to time, as may be deemed necessary by the directors or trustees of said company for the successful prosecution of its business. Such assessments may be made to meet the losses, expenses, insurance reserve, and other obligations of such company, until the whole amount of such note or obligation shall be paid. All assessments shall be made pro rata upon the entire amount of unpaid subscriptions, and, if such assessments are not paid, the same shall be collected by suit at law as other debts of like character are collectible.
Section 427. Interest on Guarantee Capital Obligations.--The subscribers to the guarantee capital of any mutual life insurance company shall be entitled to receive from such company interest, payable semi-annually at such rate, not exceeding six per centum, as may be agreed upon at the time of subscribing, if the net surplus over a requisite reservation for liabilities and contingencies is sufficient to pay the same, and, if less than the sum originally agreed on, it shall be made equal to it when the profits of the company are sufficient.

Section 428. Retirement of Guarantee Capital.--Whenever the lawful invested assets of any mutual life insurance company shall exceed the reserve and other liabilities to an amount equal to the amount of the guarantee capital subscribed, the directors or trustees, at their option, may retire or return all or such portion of the guarantee capital to the subscribers as the interest of the company may warrant; but no sum in cash shall be returned exceeding that actually paid in, with the interest due and unpaid.

Section 429. Surplus or Safety Fund.--(429 repealed June 28, 2018, P.L.351, No.48)

Section 430. Minors May be Members of Mutual Companies.--(430 repealed June 22, 1931, P.L.625, No.213)

(d) PROVISIONS RELATING TO LOCATING LIFE INSURANCE POLICIES.

(Subart. added June 28, 2018, P.L.351, No.48)

Section 441. Contact information.--The following shall apply regarding contact information:

(a) The Insurance Department shall maintain an electronic database of contact information for each life insurer that has life insurance policies or annuity contracts in force in this Commonwealth.

(b) All life insurers, including those insurers under Article XXIV, having a life insurance policy or annuity contract in force in this Commonwealth shall provide and maintain with the Insurance Department a valid e-mail address.

(441 added June 28, 2018, P.L.351, No.48)

Section 442. Life policy locator service.--The Insurance Department and all life insurers, through the contact information identified in section 441(a), shall participate in the life policy locator service adopted by the National Association of Insurance Commissioners in providing for and responding to search requests for life insurance policies or annuities in force in this Commonwealth covering a decedent.

(442 added June 28, 2018, P.L.351, No.48)

ARTICLE IV-A.

LIFE AND ENDOWMENT INSURANCE AND ANNUITIES.

(Art. added Dec. 18, 1996, P.L.1003, No.154)

Section 401-A. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Actuarial standards board." The board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

"Agent." A licensed representative of an insurer as defined in section 601 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."
"Basic illustration." A ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and nonguaranteed elements.

"Broker." A licensed representative of an insurance applicant or insured as defined in section 621 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Contract premium." The gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

"Currently payable scale." A scale of nonguaranteed elements in effect for a policy form as of the preparation date of the illustration or which has a future effective date not later than ninety-five (95) days from the date the illustration is shown.

"Department." The Insurance Department of the Commonwealth.

"Disciplined current scale." A scale of nonguaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

1. Are consistent with all provisions of this act.
2. Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred.
3. Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date.
4. Do not permit assumed expenses to be less than minimum assumed expenses.

"Existing life insurance or annuity." A life insurance or annuity policy in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity that is within an unconditional refund period where a commission and a premium have already been paid.

"Fraternal benefit society." Any entity licensed to engage in the business of insurance under the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

"Generic name." A short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

"Guaranteed elements." The premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

"Illustrated scale." A scale of nonguaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

1. the disciplined current scale; or
2. the currently payable scale.

"Illustration." Anything that purports to describe a life insurance policy or annuity in a ledger-type format reflecting guaranteed/nonguaranteed future contract premiums, premium outlays, surrender values and benefits and is used in the sales presentation.
"In-force illustration." An illustration furnished at any time after the policy that it depicts has been in force for one (1) year or more.

"Insurer." Life insurer or fraternal benefits society.

"Lapse-supported illustration." An illustration of a policy form failing the test of self-supporting as defined in this act, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 per centum (100%) policy persistency thereafter.

"Life insurance illustration." A presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years and that is a basic illustration, a supplemental illustration or an in-force illustration.

"Life insurer" or "insurer." An entity licensed to engage in the business of insurance under this act.

"Minimum assumed expenses." The minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(1) Fully allocated expenses.

(2) Marginal expenses.

(3) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the Insurance Commissioner. Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

"Nonguaranteed elements." The premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

"Nonterm group life." A group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative.

(2) Some portion of the premium is paid by the group or through payroll deduction.

(3) Group underwriting or simplified underwriting is used.

"Policy owner." The owner named in the policy or the certificateholder in the case of a group policy.

"Premiums outlay." The amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

"Producer." An agent or broker.

"Replacement." A transaction in which new life insurance or a new annuity is to be purchased and it is known to the proposing agent, broker or proposing insurer that, by reason of the transaction, existing life insurance or annuity has been or is to be one of the following:

(1) Lapsed, forfeited, surrendered, assigned to the replacing insurer or otherwise terminated.

(2) Converted to reduce paid-up insurance, continued as extended term insurance or otherwise reduced in value by the use of nonforfeiture benefits, dividend cash values or other policy cash values.

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

(4) Reissued with a reduction in cash value.
(5) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five (25%) of the loan value set forth in the policy. The term does not include group life insurance or group annuities, life insurance issued under the act of September 2, 1961 (P.L.1232, No.540), known as the "Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance," life insurance issued in connection with a pension, profit sharing or other benefit plan qualifying for deductibility of premiums, transactions involving an application to the existing insurer that issued the existing life insurance or annuity in which a contractual change or a conversion privilege is being exercised.

"Self-supporting illustration." An illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies, or upon policy expiration if sooner, the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

"Supplemental illustration." An illustration furnished in addition to a basic illustration that meets the applicable requirements of this act and that may be presented in a format differing from the basic illustration, but may only depict a scale of nonguaranteed elements that is permitted in a basic illustration.

Section 402-A. Applicability and Purpose.--Except as expressly provided, this article shall apply to all insurers licensed to do business in this Commonwealth with respect to any life insurance policy or annuity delivered or issued for delivery in this Commonwealth and to all producers licensed to sell life insurance or annuities with respect to any life insurance policy or annuity marketed or sold in this Commonwealth. The purpose of this article is to prescribe standards which shall be followed in the solicitation, sale, issuance and delivery of life insurance products and annuities.

Section 403-A. Unfair Financial Planning Practices.--(a) No producers shall hold themselves out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when that person is in fact engaged only in the sale of life or annuity insurance policies. This subsection shall not limit persons who hold some form of formally recognized financial planning or consultant designation from using this designation when they are only selling insurance. However, these persons may not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

(b) (1) Producers shall not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in subsection (c) or solicitation of the sale of a product or service that:

(i) he is also an insurance salesperson; and
(ii) a commission for the sale of an insurance product will be received from an insurer apart from a fee for financial planning, if such is the case.

(2) The disclosure requirement under this subsection may be met by including it in any disclosure required by Federal or State securities law.

(c) (1) Producers shall not charge fees, other than commissions, for financial planning unless such fees are based upon a written agreement signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by that party. The written agreement must include, at a minimum:

(i) A general description of the services for which the fee is to be charged.

(ii) The amount of the fee to be charged or how it will be determined or calculated.

(iii) The fact that the client is under no obligation to purchase any insurance product through the insurance agent, broker or consultant.

(2) The producers shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the department upon request.

(403-A added Dec. 18, 1996, P.L.1003, No.154)

Section 404-A. Delivery of Individual Policies and Annuities.--(a) For purposes of determining the commencement of the period during which the owner of an individual insurance policy or annuity may exercise any statutory right to examine, surrender or return the policy for cancellation, the date of delivery of the policy or annuity shall be:

(1) the date of mailing of the policy or annuity by the insurer if the delivery is by the United States mail or other postal delivery system;

(2) the date the policy or annuity is physically delivered to the owner by a representative of the insurer; or

(3) the date of electronic transmission of the policy or annuity provided the electronic transmission has been effected in accordance with this section and the provisions of section 354.7 and any other state or Federal laws governing the electronic transmission of documents and information. The insurer shall retain evidence of electronic transmittal for the entire period of the insurance policy or annuity.

(b) In the event of a dispute with the owner of a policy or annuity, the burden of proof shall be on the insurer to establish that the policy or annuity was delivered. An insurer or representative of the insurer shall be deemed to have satisfied the burden of proof by showing, to the department's satisfaction, it has sent the policy or annuity in the normal course of business.

(404-A amended July 10, 2015, P.L.154, No.30)

Section 405-A. Establishment of Internal Audit and Compliance Procedures.--(a) Every insurer shall institute and maintain internal audit and compliance procedures which provide for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising and filing and approval requirements for life insurance and annuities. These procedures shall also provide for the following:

(1) Periodic reviews of consumer complaints in order to identify patterns of improper practices.

(2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.
(3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

(b) Each insurer shall make available for department inspection upon request its internal audit and compliance procedures which are instituted as required by this section.

(405-A added Dec. 18, 1996, P.L.1003, No.154)

Section 406-A. Application.--No alteration of any written application for a life insurance policy or annuity shall be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.


Section 407-A. Illustrations.--(a) A producer shall only use and shall not withhold, alter, change or in any way modify the results of a life insurance or annuity illustration system provided by an insurer or approved in writing by an officer of the insurer or such other person as the insurer may designate for such purpose.

(b) Life insurance and annuity illustrations may not be made part of any life insurance or annuity policy issued.


Section 408-A. Life Insurance Illustrations.--(a) (1) Each insurer marketing policies to which this act is applicable shall notify the commissioner whether a life insurance policy form is to be marketed with or without an illustration. For all life insurance policy forms being actively marketed on the effective date of this section, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. The notification shall be provided within sixty (60) days of the effective date of this section. For life insurance policy forms approved by the department but not being actively marketed on the effective date of this section, the identification shall be made on or before the time the life insurance policy form is actively marketed. For life insurance policy forms filed with the commissioner after the effective date of this section, the identification shall be made at the time of filing.

(2) Any previous identification may be changed by notice to the commissioner. This notice shall be provided on or before the effective date of the change.

(3) If the insurer identifies a life insurance policy form as one to be marketed without an illustration, any use of an illustration with any policy using that policy form prior to the first policy anniversary is prohibited.

(4) If a life insurance policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this section is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite
(5) Potential enrollees for policies and certificates on nonterm group life subject to this section shall show potential policy values from sample ages and policy years on a guaranteed and nonguaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this section, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the life insurance policy or certificate to enrollees for nonterm group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any nonterm group life enrollee who requests it.

(b) (1) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this section, be clearly labeled "life insurance illustration" and contain the following basic information:

(i) Name of insurer.

(ii) Name and business address of producer, if any.

(iii) Name, age and sex of proposed insured, except where a composite illustration is permitted under this section.

(iv) Underwriting or rating classification upon which the illustration is based.

(v) Generic name of policy, the insurer product name, if different, and form number.

(vi) Initial death benefit.

(vii) Dividend option election or application of nonguaranteed elements, if applicable.

(2) When using an illustration in the sale of a life insurance policy, an insurer or its producers shall not:

(i) represent the policy as anything other than a life insurance policy;

(ii) use or describe nonguaranteed elements in a manner that is untrue, deceptive or misleading or has the capacity or tendency to mislead;

(iii) state or imply that the payment or amount of nonguaranteed elements is guaranteed;

(iv) use an illustration that does not comply with the requirements of this act;

(v) use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

(vi) provide an applicant with an incomplete illustration;

(vii) represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits unless such representation is true;

(viii) use the term "vanish" or "vanishing premium" or any similar term that implies the policy may become paid up to describe a plan whereby nonguaranteed elements are used to pay all or a portion of future premiums;

(ix) except for policies that can never develop nonforfeiture values, use a lapse-supported illustration; or

(x) use an illustration that is not self-supporting.

(3) If an interest rate used to determine the illustrated nonguaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.
(c) (1) A basic illustration shall conform with the following requirements:

(i) The illustration shall be labeled with the date on which it was prepared.

(ii) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration.

(iii) The assumed dates of payment receipt and benefit payout within a policy year shall be clearly identified.

(iv) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the number of years the policy is assumed to have been in force.

(v) The assumed payments in which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

(vi) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(vii) If the illustration shows any nonguaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled nonguaranteed.

(viii) The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements.

(ix) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

(x) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

(xi) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

(xii) Any illustration of nonguaranteed elements shall contain a statement indicating that:

(A) The benefits and values are not guaranteed.

(B) The assumptions on which they are based are subject to change by the insurer.

(C) Actual results may be more or less favorable.

(xiii) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using nonguaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlays of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

(xiv) Upon the request of the applicant and at the discretion of the insurer, the illustration may show the use of dividends or policy values, guaranteed or nonguaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, and the impact of such use on future policy benefits and values.
(2) A basic illustration shall include the following:
(i) A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
(ii) A brief description of the premium outlay or contract premium, as applicable for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.).
(iii) A brief description of any policy features, riders or options, guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy.
(iv) Identification and a brief definition of column headings and key terms used in the illustration.
(v) A statement containing in substance the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

(3) (i) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10) and twenty (20) and at age seventy (70), if applicable. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).
(ii) This numeric summary shall be shown for the required policy years for the following three bases:
(A) Policy guarantees.
(B) Insurer's or fraternal benefit society's illustrated scale.
(C) Insurer's or fraternal benefit society's illustrated scale used but with the nonguaranteed elements reduced as follows:
(1) Dividends at fifty per centum (50%) of the dividends contained in the illustrated scale used.
(2) Nonguaranteed credited interest at rates that are the arithmetic average of the guaranteed rates and the rates contained in the illustrated scale used.
(3) All nonguaranteed charges, including, but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
(iii) In addition, if coverage would cease prior to maturity or age one hundred (100) for a policy without a maturity date, on any of the three bases stated in subparagraph (ii), the years in which coverage ceases shall be identified.
(4) Statements substantially similar to the following shall be included on the same page as the numeric summary:
(i) A statement to be signed and dated by the applicant or the policy owner in the case of an illustration provided at time of delivery, reading as follows: "I have received a copy of this illustration and understand that any nonguaranteed elements illustrated are subject to change and could be either higher or lower. The producer has told me they are nonguaranteed."
(ii) A statement to be signed and dated by the producer, reading as follows:

"I certify that this illustration has been presented to the applicant or the policy owner and that I have explained that any nonguaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

(5) (i) A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at the later of age one hundred (100), policy maturity or final expiration; and except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(A) The premium outlay, the payment mode the applicant plans to use and the contract premium, as applicable.

(B) The corresponding guaranteed death benefit, as provided in the policy.

(C) The corresponding guaranteed value available upon surrender, as provided in the policy.

(ii) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(iii) Nonguaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any nonguaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a nonguaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

(d) (1) A supplemental illustration may be provided so long as:

(i) It is appended to, accompanied by or preceded by a basic illustration that complies with this section.

(ii) The nonguaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration.

(iii) It contains the statement referenced in subsection (c)(1)(xii), exactly as contained in the basic illustration.

(iv) For a policy that provides for a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

(2) The supplemental illustration shall include a notice referring to the basic illustration and that the basic illustration contains guaranteed elements and other important information.

(e) (1) The following applies if a basic illustration is used by a producer in the sale of a life insurance policy.

(i) If the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this section, shall be submitted to the insurer no later than the time the policy application is sent to the insurer. A copy shall also be provided to the applicant no later than the time the application is signed by the applicant.

(ii) If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued
shall be mailed or delivered with the policy. The revised illustration shall conform to the requirements for basic illustrations contained in this act and shall be labeled "Revised Illustration." The statement required by subsection (c)(4) shall be signed and dated by the policy owner and producer no later than the time the policy is delivered. A copy shall be provided to the policy owner no later than the time the policy is delivered and to the insurer as soon as practical after the policy is delivered.

(2) The following applies if no illustration is used by a producer in the sale of a life insurance policy or if a computer screen illustration is displayed.

(i) The producer shall certify in writing on a form provided by the insurer that no illustration was used in the sale of the life insurance policy. On the same form the applicant shall acknowledge that no illustration was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer as soon as practical after the application is signed by the applicant.

(ii) Where a computer screen illustration is used, the producer shall certify in writing on a form provided by the insurer that a computer screen illustration was displayed. Such form shall require the producer to provide, as applicable, the generic name of the policy and any riders illustrated, the guaranteed and nonguaranteed interest rates illustrated, the number of policy years illustrated, the initial death benefit, the premium amount illustrated and the assumed number of years of premiums. On the same form, the applicant shall further acknowledge that an illustration matching that which was displayed on the computer screen will be provided no later than the time the application is provided to the insurer. A copy of this signed form shall be provided to the applicant at the time it is signed.

(iii) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed by the policy owner no later than the time the policy is delivered. A copy shall be provided to the policy owner at the time the policy is delivered and to the insurer as soon as practical after the policy is delivered.

(3) The following applies if an illustration is used by a producer in the sale of a life insurance policy but the policy applied for is other than as illustrated.

(i) The producer shall certify in writing on a form provided by the insurer that the policy applied for is other than as illustrated. On the same form the applicant shall acknowledge that the policy applied for is other than as illustrated and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer or fraternal benefit society as soon as practical after the application is signed by the applicant.

(ii) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed by the policy owner no later than the time the policy is delivered. A copy shall be provided to the policy owner no later than the time the policy is delivered and to the insurer as soon as practical after the policy is delivered.

(4) If the basic or revised illustration is mailed to the applicant or policy owner by the insurer, the applicant or policy owner shall be instructed to sign the duplicate copy of
the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that a diligent effort has been made to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

(5) A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued.

(f) (1) The board of directors of each insurer shall appoint one or more illustration actuaries.

(2) The illustration actuary shall certify that the disciplined current scale used in illustrations in conformity with the Actuarial Standard of Practice for Compliance promulgated by the Actuarial Standards Board and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this section.

(3) The illustration actuary shall:

   (i) Be a member in good standing of the American Academy of Actuaries.
   (ii) Be familiar with the standard of practice regarding life insurance policy illustrations.
   (iii) Not have been found guilty of fraudulent or dishonest practices by a court of competent jurisdiction.
   (iv) Not have been found by the commissioner, following appropriate notice and hearing, to have:

       (A) violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her duties as an illustration actuary;
       (B) demonstrated his or her incompetence, lack of cooperation or untrustworthiness to act as an illustration actuary; or
       (C) resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards.
   (v) Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that of subparagraph (iv).

(4) The illustration actuary shall disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in-force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in-force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited, this must be disclosed in the annual certification.
(5) The illustration actuary shall disclose in the annual certification the method used to allocate overhead expenses for all illustrations:
   (i) fully allocated expenses;
   (ii) marginal expenses; or
   (iii) a generally recognized expense table based on fully allocated expense representing a significant portion of insurance companies and approved by the commissioner.

(6) The illustration actuary shall file a certification with the insurer's or fraternal benefit society's board and with the commissioner:
   (i) Annually for all life insurance policy forms for which illustrations are used.
   (ii) Before a new life insurance policy form is illustrated.

(7) If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the commissioner promptly in writing.

(8) If an illustration actuary is unable to certify the scale for any life insurance policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly in writing of his or her inability to certify.

(9) A responsible officer of the insurer, other than the illustration actuary, shall certify annually that:
   (i) The illustration formats meet the requirements of this section and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary.
   (ii) The insurer has provided its producers with information about the expense allocation method used by the insurer in its illustrations and has made the disclosure required in paragraph (5).

(10) The annual certification required by paragraph (6)(i) shall be provided to the commissioner each year by a date determined by the insurer but no later than one year after the effective date of this section. Subsequent annual certifications shall be provided within thirty (30) days before or after the anniversary of the first certification. The certification required by paragraph (6)(ii) shall be provided at least thirty (30) days prior to using an illustration with a new life insurance policy form.

(11) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly in writing and disclose the reason for the change.

(g) This section shall not apply to:
(1) Variable life insurance.
(2) Credit life insurance.
(3) Life insurance issued in connection with a pension, profit-sharing or other benefit plan qualifying for deductibility of premiums.
(4) Life insurance policies for which there are no illustrated death benefits exceeding ten thousand dollars ($10,000) on any individual.

(h) This section shall expire on the effective date of approved final-form regulations promulgated hereunder as published in the Pennsylvania Bulletin under the provisions of the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

(408-A added Dec. 18, 1996, P.L.1003, No.154)

Section 409-A. Replacements With the Same Insurer or Insurer Group.--When there is solicitation for the replacement of an
existing life insurance policy or annuity with the same insurer or insurer group, the insurer shall, through its producers where appropriate, provide a "Notice Regarding Replacement of Life Insurance and Annuities" in the form set forth under 31 Pa. Code Ch. 81 (relating to replacement of life insurance and annuities).

(409-A added Dec. 18, 1996, P.L.1003, No.154)

Section 410-A. Enforcement.--(a) Upon a determination by hearing that this act has been violated by any person subject to its terms, the commissioner may pursue one or more of the following courses of action:

(1) Issue an order requiring the person to cease and desist from engaging in such violation or suspend or revoke or refuse to issue the certificate of qualification or license of the offending party or parties.

(2) Impose a civil penalty of not more than five thousand dollars ($5,000) for each violation.

(b) The enforcement remedies imposed under this section are in addition to any other remedies or penalties imposed by any other applicable statute.

(c) Any action or adjudication of the commissioner under this section shall be preceded by a hearing in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and subject to review and appeal in accordance with 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).


Section 411-A. Powers of Commissioner.--(a) The commissioner may promulgate the rules and regulations necessary for the administration of this act.

(b) The commissioner may examine and investigate the affairs of every person engaged in the business of insurance in this Commonwealth in order to determine whether the person has been or is engaged in any act or practice prohibited by this act.

(411-A added Dec. 18, 1996, P.L.1003, No.154)

ARTICLE IV-B
SUITABILITY OF ANNUITY TRANSACTIONS

Section 401-B. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Annuity." An annuity that is an insurance product and is individually solicited, whether the insurance product is classified as an individual or group annuity.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Continuing education credit." One continuing education credit under section 608-A of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

"Continuing education provider." An individual or entity approved to offer continuing education courses under section 608-A of The Insurance Department Act of 1921.

"Department." The Insurance Department of the Commonwealth.

"FINRA." The Financial Industry Regulatory Authority or a succeeding agency.

"General agent." An insurance producer that provides supervision on behalf of an insurer to an insurer's sales force in a particular geographic region or territory.

"Independent agency" (Deleted by amendment).
"Insurance producer." A person who sells, solicits or negotiates contracts of insurance as defined in section 601-A of The Insurance Department Act of 1921.

"Insurer." A life insurance company licensed or required to be licensed under section 202 or a fraternal benefit society as defined in section 2403.

"Recommendation." Advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

"Replace" or "replacement." The purchase of a new policy or contract where it is known or should be known to the proposing producer, or to the proposing insurer if there is no insurance producer, that by reason of the transaction, an existing policy or contract has been or will be:

(1) lapsed, forfeited, surrendered or partially surrendered or assigned to the replacing insurer or otherwise terminated;
(2) converted to reduced paid-up insurance, continued as extended term insurance or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
(3) amended so as to effect a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
(4) reissued with a reduction in cash value; or
(5) used in a financed purchase.

"Suitability information." Information relating to an annuity that is appropriate to determine the suitability of a recommendation, including:

(1) Age.
(2) Annual income.
(3) Financial situation and needs, including the financial resources used for the funding of the annuity.
(4) Financial experience.
(5) Financial objectives.
(6) Intended use of the annuity.
(7) Financial time horizon.
(8) Existing assets, including investment and life insurance holdings.
(9) Liquidity needs.
(10) Liquid net worth.
(11) Risk tolerance.
(12) Tax status.

(401-B amended June 28, 2018, P.L.351, No.48)

Section 402-B. Applicability and scope of article.

(a) General rule.--This article shall apply to any recommendation to purchase or replace an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase or replacement recommended.

(b) Exclusions.--Unless otherwise specifically included, this article shall not apply to recommendations involving the following:

(1) Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this article.

(2) Contracts used to fund:

(i) An employee pension or welfare benefit plan that is covered by the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

(ii) A plan described by sections 401(a) or (k), 403(b), 408(k) or (p) of the Internal Revenue Code of
1986 (Public Law 99-514, 26 U.S.C. §§ 401(a) or (k), 403(b), 408(k) or (p)), when the plan, for purposes of the Employee Retirement Income Security Act of 1974, is established or maintained by an employer.

(iii) A governmental or church plan defined in section 414 of the Internal Revenue Code of 1986 or a deferred compensation plan of a State or local government or tax exempt organization under section 457 of the Internal Revenue Code of 1986.

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(v) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process.

(vi) Formal prepaid funeral contracts.

(402-B amended June 28, 2018, P.L.351, No.48)

Section 403-B. Duties of insurers and insurance producers.

(a) General duties.--In making a recommendation to a consumer for the purchase or replacement of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no insurance producer is involved, shall have reasonable grounds for believing that:

(1) The recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's suitability information.

(2) The consumer has been reasonably informed of various features of the annuity, including the potential surrender period and surrender charge, potential tax penalty if the consumer sells, replaces, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk.

(3) The consumer would benefit from certain features of the annuity, including tax-deferred growth, annuitization or death or living benefit.

(4) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or replacement of the annuity, and riders and similar product enhancements, if any, are suitable and, in the case of a replacement, the transaction as a whole is suitable for the consumer based on the consumer's suitability information.

(5) In the case of a replacement of an annuity, the replacement is suitable and shall take into consideration whether:

(i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, including death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements.

(ii) The consumer would benefit from product enhancements and improvements.

(iii) The consumer has had another annuity replacement, including a replacement within the preceding 36 months.

(b) Consumer information.--Prior to the execution of a purchase or replacement of an annuity resulting from a
recommendation, an insurance producer, or an insurer where no insurance producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

(1) (Deleted by amendment).
(2) (Deleted by amendment).
(3) (Deleted by amendment).
(4) (Deleted by amendment).

(b.1) Reasonable basis.--Except as permitted under subsection (c), an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

(c) Obligation limits.--
(1) Except as provided under paragraph (2), neither an insurance producer nor an insurer where no insurance producer is involved shall have any obligation to a consumer under subsection (a) or (b.1) related to any annuity transaction if:

  (i) No recommendation is made.
  (ii) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer.
  (iii) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended.
  (iv) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

(2) An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

(c.1) Documentation.--An insurance producer, or the responsible insurer representative if no insurance producer is involved, shall at the time of sale of an annuity:

  (1) Make a record of each recommendation subject to subsection (a).
  (2) Obtain a customer-signed statement documenting a customer's refusal to provide suitability information, if any.
  (3) Obtain a customer-signed statement acknowledging that an annuity transaction is not recommended if the customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

(d) Supervision of recommendations.--
(1) An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its insurance producer's compliance with this article, including, but not limited to, the following:

  (i) The insurer shall maintain reasonable procedures to inform its insurance producers of the requirements of this article and shall incorporate the requirements of this article into relevant insurance producer training manuals.
  (ii) The insurer shall establish standards for insurance producer product training and maintain reasonable procedures to require its insurance producers to comply with the requirements of section 403.1-B.
  (iii) The insurer shall provide product-specific training and training materials that explain all material
features of its annuity products to its insurance producers.

(iv) The insurer shall maintain procedures for review of each recommendation before issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. The review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means, including, but not limited to, physical review. The electronic or other system may be designed to require additional review only for those transactions identified for additional review by the selection criteria.

(v) The insurer shall maintain reasonable procedures to detect recommendations that are not suitable, including, but not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph shall prevent an insurer from complying with this subparagraph by applying sampling procedures or by confirming suitability information after issuance or delivery of the annuity.

(vi) The insurer shall annually provide a report detailing its supervision system to senior management, including to the senior manager responsible for audit functions. The report shall include a description of the testing designed to determine the effectiveness of the supervision system, the exceptions found and the corrective action taken or recommended, if any.

(2) Nothing in this subsection shall restrict an insurer from contracting for performance of a function, including maintenance of procedures, required under paragraph (1). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties under section 406-B regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with paragraph (3).

(i) (Deleted by amendment).

(ii) (Deleted by amendment).

(3) An insurer's supervision system under paragraph (1) shall include supervision of contractual performance under paragraph (2), including, but not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed.

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the senior manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(4) An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers for products other than the annuities offered by the insurer.

(i) (Deleted by amendment).

(ii) (Deleted by amendment).

(5) (Deleted by amendment).

(6) (Deleted by amendment).

(7) (Deleted by amendment).

(8) (Deleted by amendment).
(d.1) Dissuasion.--An insurance producer may not dissuade, or attempt to dissuade, a consumer from:

1. Truthfully responding to an insurer's request for confirmation of suitability information.
2. Filing a complaint.
3. Cooperating with the investigation of a complaint.

(e) Compliance with other rules.--Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this section. This subsection applies to FINRA broker-dealer sales of annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the commissioner's ability to enforce or investigate the provisions of this article. For this subsection to apply, an insurer shall:

1. Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business.
2. Provide to the FINRA member broker-dealer information and reports which are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

(f) Internal audit and compliance procedures.--Nothing in this article shall exempt an insurer from the internal audit and compliance procedure requirements under section 405-A.

(403-B amended June 28, 2018, P.L.351, No.48)

Section 403.1-B. Insurance producer training.

(a) Continuing education credits.--An insurance producer who has the authority to sell annuities shall complete at least four continuing education credits in an annuity training course or courses covering the following topics:

1. The types of annuities and various classifications of annuities.
2. Identification of the parties to an annuity.
4. The application of income taxation of qualified and nonqualified annuities.
5. The primary uses of annuities.
6. Appropriate sales practices, replacement and disclosure requirements.

(b) Compliance.--The continuing education credit requirement under subsection (a) shall be met on or before the end of the insurance producer's next complete license period occurring after the effective date of this section. For individuals licensed on or after the effective date of this section, the requirement shall be met on or before the end of the insurance producer's first license period.

(c) Course requirements.--For a course to comply with the requirements of this subsection, it shall cover all topics listed under subsection (a) and may not contain any marketing information, provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to those required.

(d) Provider registration.--A provider of an annuity training course intended to comply with this subsection shall register as a continuing education provider in this Commonwealth and comply with the rules and guidelines applicable to insurance producer continuing education courses.

(e) Course method.--Annuity training courses may be conducted and completed by classroom or self-study methods.
(f) Reporting requirements.--A continuing education provider
of annuity training shall comply with reporting requirements
and shall issue certificates of completion.

(g) Satisfaction in other states.--The satisfaction of the
training requirements of another state that are substantially
similar to the provisions of this subsection shall be deemed
to satisfy the training requirements of this subsection for
resident and nonresident producers.

(h) Verification.--An insurer shall verify that an insurance
producer has completed the annuity training course required
under this subsection within the time period specified under
subsection (b). An insurer may satisfy its responsibility under
this subsection by obtaining certificates of completion of the
training course or obtaining reports provided by the
commissioner-sponsored database systems or vendors or from a
reasonably reliable commercial database vendor that has a
reporting arrangement with approved insurance education
providers.

(403.1-B added June 28, 2018, P.L.351, No.48)

Section 404-B. Mitigation of responsibility.

(a) Corrective actions.--An insurer is responsible for
compliance with this article. If a violation occurs, either
because of the action or inaction of an insurer or its insurance
producer, the commissioner may order:

1. An insurer to take reasonably appropriate corrective
   action for any consumer harmed by the insurer's or by its
   insurance producer's violation of this article.

2. (Deleted by amendment).

3. An exclusive general agent or the insurance producer
to take reasonably appropriate corrective action for any
consumer harmed by the licensee's violation of this article.

4. Penalties and remedies under section 406-B.

(b) Reduction of penalty.--Any applicable penalty permitted
under section 406-B for a violation of this article may be
reduced or eliminated if corrective action for the consumer was
taken promptly after a violation was discovered or the violation
was not part of a pattern or practice.

(404-B amended June 28, 2018, P.L.351, No.48)

Section 405-B. Recordkeeping.

(a) General rule.--An insurer, exclusive general agent and
insurance producer shall maintain or be able to make available
to the commissioner records of the information collected from
the consumer and other information used in making the
recommendations that were the basis for the insurance
transactions for five years after the insurance transaction is
completed by the insurer. An insurer is permitted but shall not
be required to maintain documentation on behalf of an insurance
producer.

(b) Form of records.--Records required to be maintained
under this article may be maintained in paper, photographic,
microprocess, magnetic, mechanical or electronic media or by
any process that accurately reproduces the actual document.

(405-B amended June 28, 2018, P.L.351, No.48)

Section 406-B. Enforcement.

(a) Penalties and remedies.--Upon a determination by hearing
that this article has been violated, the commissioner may pursue
one or more of the following courses of action:

1. Issue an order requiring the person in violation
to cease and desist from engaging in the violation.

2. Suspend or revoke or refuse to issue or renew the
certificate or license of the person in violation.
(3) Impose a civil penalty of not more than $5,000 for each violation.

(4) Impose any other penalty or remedy deemed appropriate by the commissioner, including restitution.

(b) Other remedies.--The enforcement remedies imposed under this section are in addition to any other remedies or penalties that may be imposed by any other applicable statute, including the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. Violations of this article are deemed and defined by the commissioner to be an unfair method of competition and an unfair or deceptive act or practice pursuant to the Unfair Insurance Practices Act.


Section 407-B. Private cause of action.

Nothing in this article shall be construed to create or imply a private cause of action for a violation of this article.


Section 408-B. Regulations.

The department may promulgate rules and regulations necessary for the administration of this article.

(408-B added June 28, 2018, P.L.351, No.48)

ARTICLE V.

FIRE AND MARINE INSURANCE.

(a) GENERAL PROVISIONS RELATING TO STOCK AND MUTUAL COMPANIES, AND TO ASSOCIATIONS AND EXCHANGES.


Section 503. Annual Returns of Business.--Every foreign stock and mutual fire insurance company, association, or exchange shall, annually and at such other times as the Insurance Commissioner may require, in addition to all returns now by law required of it or its agents or managers, make a return to the Insurance Commissioner, in such form and detail as may be prescribed by him, of all insurance, reinsurance, or cessions of risks or liability contracted for or effected by it, whether by issue of policy, entry on bordereau, or general participation agreement, or by excess loss reinsurance, or in any other manner whatsoever upon property located in this State, or covering, whether specified or otherwise, any risk or liability upon property so located. Such return shall be certified by the oath of its president and secretary or attorney, if a company, association, or exchange of one of the United States, and, if a company or association of a foreign country, by the oath of its managers in the United States, as to such reinsurance or cessions effected through its branch office in the United States, and by the oath of its president and secretary, or by officers corresponding thereto at its home office, wherever located, as to reinsurance or cessions as aforesaid contracted for or effected through the foreign office. The refusal of any such company, association, or exchange to make the returns herein required shall be presumptive evidence that it is guilty of violating the provisions of the next preceding section of this act, and shall subject it to the
penalties prescribed and imposed by section five hundred and four (504) of this act.

(503 amended Mar. 21, 1929, P.L.48, No.43)

Section 504. Penalties; Revocation of License.--Any foreign stock or mutual fire insurance company, association, or exchange violating or failing to observe and comply with any of the provisions of sections five hundred and one (501), five hundred and two (502), and five hundred and three (503) of this act, shall be subject to a penalty of five hundred dollars ($500) for each violation thereof. Such penalty, upon satisfactory evidence of the violation of any of the preceding sections by any foreign stock or mutual fire insurance company, association, or exchange, may be imposed by the Insurance Commissioner. Any such fire insurance company, association, or exchange which shall neglect and refuse, for thirty days after the imposition of any penalty by the Insurance Commissioner, to pay and discharge the amount thereof shall have its authority to transact business in this State revoked by the Insurance Commissioner, and such revocation shall continue for at least one year from the date thereof. No such fire insurance company, association, or exchange, whose authority to transact business in this State shall have been so revoked, shall be again authorized or permitted to transact business herein until it shall have paid the amount of any such penalty, and shall have filed in the office of the Insurance Commissioner a certificate, signed by its president or other chief officer, to the effect that the terms and obligations of the provisions of this act are accepted by it as a part of the conditions of its right and authority to transact business in this State. Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of such alleged violation, and fixing a time and place, at least ten (10) days thereafter, when a hearing of the matter shall be held. After such hearing or upon failure of the accused to appear at such hearing, the Insurance Commissioner shall impose such of the above penalties as he deems advisable.


Section 505. Reports of Fires to Bureau of Fire Protection.--Reports of or mutual fire insurance company, association, or exchange transacting business in this State shall file with the Bureau of Fire Protection in the Department of State Police annual and monthly reports in writing, containing such information as is required to be reported by such companies, associations, and exchanges pursuant to the provisions of the act of July first, one thousand nine hundred and nineteen (Pamphlet Laws, seven hundred and ten P.L.710), entitled "An act relating to fires and fire prevention imposing duties, and conferring powers heretofore exercised by the State Fire Marshal, upon the Department of State Police; authorizing the appointment of the chiefs of fire departments and certain public officers and others as assistants to said department, and defining their powers and duties; providing for the investigation of the cause, origin, and circumstance of fires, and the inspection of all and the removal or change of certain buildings; imposing duties on school authorities, and on certain corporations, associations, and fire rating agencies; providing for the attendance of witnesses before the department, and the enforcement of its orders; and prescribing penalties," or its amendments or supplements. Failure to make such report shall
subject such company, association, or exchange to the penalties prescribed in said act, and, in addition thereto, such company, association, or exchange shall forfeit its right to do business in this State.

Section 506. Fire Insurance Contract; Standard Policy Provisions; Permissible Variations.--

1. As used in this section, the term "fire insurance" shall mean insurance against loss by fire, lightning or removal, as specified in paragraph (1) of subsection (b) of section 202 of this act, as amended, and the term shall not include insurances of the kind specified in any other portion of that section, amended as aforesaid, whether or not the risks of fire, lightning or removal be included.

2. Except as provided elsewhere in this section, no insurance company, association or exchange shall issue a policy affording fire insurance, as defined in this section, on property in this Commonwealth, unless such policy contains the following provisions as to such insurance:

No.

In Consideration of the Provisions and Stipulations herein or added hereto and of ........................................ Dollars Premium this company, for the term of ............. from the .. day of .. 19.. at noon, Standard Time, at to the .... day of .. 19.. location of property involved, to an amount not exceeding ................. Dollars, doesinsure.................................................... and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increase cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

IN WITNESS WHEREOF, this Company has executed and attested these presents: but this policy shall not be valid unless countersigned by the duly authorized agent of this Company at

..........................................................
Secretary.  President.

Countersigned this ...... day of ............. 19 ..............
Agent.
Concealment, fraud--This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property--This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included--This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance--Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring
(a) while the hazard is increased by any means within the control or knowledge of the insured; or
(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or
(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects--Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

Added provisions--The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions--No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy--This policy shall be cancelled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand.
Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations--If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation. If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability--This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs--The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal--In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The
appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.

Company's options--It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment--There can be no abandonment to this Company of any property.

When loss payable--The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit--No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within twelve months next after inception of the loss.

Subrogation--This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

There may be printed upon the face of a policy which contains such provisions the words "Standard Fire Insurance Policy of the State of Pennsylvania" and including the name of any other states which adopt this form of policy.

3. The provisions of subsection two of this section shall not apply to policies of perpetual insurance, policies of reinsurance, policies of an all-risk type, policies insuring aircraft, automobile or other motor vehicles against loss by fire, or policies insuring against loss by fire resulting directly or indirectly from bombardment, invasion, insurrection, riot, civil war, commotion, or military or usurped power, or by order of civil authority.

4. A policy affording fire insurance, as defined in this section, may, subject to the approval of the Insurance Commissioner as provided in section 354 of this act, include any other insurances which the insurer is authorized to make, and the wording set out in subsection two of this section may be modified in conformity with the provisions thereof or to accommodate additional property coverages and perils.

5. Notwithstanding any other provisions of this section:

(a) An insurer may print on its policy its name, such device or devices as the insurer issuing said policy may desire, the location of its principal office, and the date of its formation, plan of operation, the amount of its paid up capital, if any, the name of its officers and agents, the number and date of the policy, and, if it is issued through an agent, the words "this
policy shall not be valid unless countersigned by the duly authorized agent of the company at .......... "

(b) An insurer may print in its policies any provisions which it is authorized or required by law to insert therein, and an insurer not organized under the laws of this Commonwealth may, with the approval of the Insurance Commissioner, so print any provisions required by its charter or deed of settlement or by the laws of its own state or country not contrary to the law of this Commonwealth.

(c) An insurer may add either upon the face of the policy or on the riders or endorsements to be attached thereto, printed or written forms of description and specification or schedules of the property covered by any particular policy and any other matter necessary to express clearly all the facts and conditions of insurance on any particular risk. Insurers issuing the standard policy defined in this section are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy. Nothing contained in this subsection shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination. Any endorsements or riders so attached must be signed by officers or agents of the company so issuing them.

(d) Binders or other contracts for temporary insurance, including fire insurance, as defined in this section, may be made orally or in writing, for a period which shall not exceed thirty days, and shall be deemed to include all the provisions of subsection two of this section and all such applicable endorsements approved by the Insurance Commissioner as may be designated in such contract of temporary insurance, except that the cancellation clause and the clause thereof specifying the hour of the day at which the insurance shall commence may be provided by the express terms of such contract of temporary insurance.

(e) Appropriate forms of supplemental contracts or extended coverage endorsements whereby the interest in the property described in a policy affording fire insurance, as herein defined, shall be insured against one or more of the other perils which the insurer is empowered to assume may be approved by the Insurance Commissioner, and their use in connection with such fire insurance policy may be authorized by him. A form of policy affording fire insurance, as herein defined, may be arranged to provide space for the listing of amounts of insurance, with insurance rates and premiums for the basic coverage insured thereunder, and for additional coverages or perils insured under endorsements attached, and such other data as may be conveniently included for duplication on daily reports for office records.

6. The form of policy, including fire insurance, as defined in this section, upon property in this Commonwealth, shall be plainly printed, and no portion thereof shall be in type smaller than seven (7) point.

7. After the effective date of this amendment, any insurance company, association or exchange not heretofore required to comply with the provisions of this act fixing standard policy provisions for fire insurance contracts, may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this section after a specified
date, upon which date this section shall become operative with respect to the policies and contracts thereafter issued by such company, association or exchange: Provided, however, That the operative date for every insurance company, association or exchange shall not in any event be later than January first, one thousand nine hundred sixty-three.

8. In addition to the other provisions of this section, no foreign fire insurance company shall issue a policy affording fire insurance, as described in this section, on property in this Commonwealth, unless such policy contains the exact name of the city, borough, incorporated town or township wherein the insured property is located in addition to the mailing address for each such insured property. (8 added Mar. 13, 1974, P.L.187, No.33)

9. Insurers issuing or renewing the standard fire insurance policy defined in this section for commercial business are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by terrorism, whether directly or indirectly resulting from an insured peril under the policy. As used in this section, "terrorism" means any of the following:

(a) a certified act of terrorism as defined in the Terrorism Risk Insurance Act of 2002 (Public Law 107-297, 116 Stat.2322);
(b) a violent act or an act that is dangerous to human life, property or infrastructure that is committed by an individual or individuals acting on behalf of a foreign person or foreign interest and that appears to be part of an effort to coerce a civilian population or to influence the policy or affect the conduct of any government by coercion; or
(c) terrorism as defined in a form filed with and approved by the Insurance Commissioner.
(9 added July 7, 2006, P.L.1045, No.104)
(506 added Aug. 23, 1961, P.L.1081, No.488)

Section 506.1. After-Death Continuation of Basic Property Insurance.--(a) Basic property insurance shall be continued one hundred and eighty (180) days after the death of the named insured on the policy or until the sale of the property, whichever event occurs first, provided that the premiums for the coverage are paid.
(b) The phrase "basic property insurance," as used in this section, shall be construed to include all policies that provide insurance against direct loss to real or tangible personal property at a fixed location caused by perils defined and limited in the standard fire policy prescribed in section five hundred and six (506) of this act and in the extended coverage endorsement approved by the Insurance Commissioner pursuant to section three hundred and fifty-four (354) of this act and such vandalism, malicious mischief, burglary, theft or such other classes of insurance as may be determined by the Insurance Commissioner, but shall not include insurance on motor vehicle, farm or such manufacturing risks as may be excluded by the Insurance Commissioner.
(506.1 added July 9, 1992, P.L.678, No.98)

Section 507. Penalty for Issuing Other than Standard Fire Policies.--Upon satisfactory evidence that any person, corporation, or insurance company, association or exchange has issued, or caused to be issued, any policy or contract of fire insurance on property situated in this Commonwealth contrary to the provisions of section 506 of this act, the Insurance Commissioner may, in his discretion, take, against the offending party, any one or more of the following courses of actions: (1) suspend or revoke the license of such offending person,
corporation, or insurance company, association or exchange; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such offending person, corporation, or insurance company, association or exchange; (3) impose a penalty of not more than one thousand dollars ($1,000) for each act of violation of said section. Any person, corporation, or insurance company, association or exchange that shall, either as principal or agent, wilfully issue, or cause to be issued, any policy or contract of fire insurance on property situated within this Commonwealth contrary to the provisions of section 506 of this act, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding five hundred dollars ($500). Any policy issued in violation of this act shall nevertheless be construed in accordance with the provisions of this act.


Section 508. Municipal Certificate Required Prior to Payment of Fire Loss Claims.--(a) No insurance company, association or exchange doing business in this Commonwealth shall pay a claim of a named insured for fire damage to a structure located within a municipality where the amount recoverable for the fire loss to the structure under all policies exceeds seven thousand five hundred dollars ($7,500) unless the insurance company, association or exchange is furnished with a certificate pursuant to subsection (b) of this section and unless there is compliance with the procedures set forth in subsections (c) and (d) of this section.

(b) (1) The municipal treasurer shall, upon the written request of the named insured specifying the tax description of the property, name and address of the insurance company, association or exchange and the date agreed upon by the insurance company, association or exchange and the named insured as the date of the receipt of a loss report of the claim, furnish the insurance company, association or exchange either of the following within fourteen (14) working days of the request:

(i) a certificate or, at the discretion of the municipality, a verbal notification which shall be confirmed in writing by the insurer to the effect that, as of the date specified in the request, there are no delinquent taxes, assessments, penalties or user charges against the property and that, as of the date of the treasurer's certificate or verbal notification, no municipality has certified any amount as total costs incurred by the municipality for the removal, repair or securing of a building or other structure on the property; or

(ii) a certificate and bill showing the amount of delinquent taxes, assessments, penalties and user charges against the property as of the date specified in the request that have not been paid as of the date of the certificate and also showing, as of the date of the treasurer's certificate, the amount of the total costs, if any, certified to the treasurer that have been incurred by a municipality for the removal, repair or securing of a building or other structure on the property. For the purposes of this subclause, the municipality shall certify to the treasurer the total amount, if any, of such costs. A tax, assessment, penalty or user charge becomes delinquent at the time and on the date a lien could otherwise have been filed against the property by the municipality under applicable law.

(2) (i) Upon the receipt of a certificate pursuant to clause (1)(i) of this subsection, the insurance company, association or exchange shall pay the claim of the named insured
in accordance with the policy terms, unless the loss agreed to between the named insured and the company, association or exchange equals or exceeds sixty per centum (60%) of the aggregate limits of liability on all fire policies covering the building or other structure. In the case of such a loss, the insurance company, association or exchange, the insured property owner and the municipality shall follow the procedures set forth in subsections (c) and (d) of this section.

(ii) Upon the receipt of a certificate and bill pursuant to clause (1)(ii) of this subsection, the insurance company, association or exchange shall return the bill to the treasurer and transfer to the treasurer an amount from the insurance proceeds necessary to pay the taxes, assessments, penalties, charges and costs as shown on the bill. The municipality shall receive the amount and apply or credit it to payment of the items shown in the bill.

(c) When the loss agreed to between the named insured and the company, association or exchange equals or exceeds sixty per centum (60%) of the aggregate limits of liability on all fire policies covering the building or other structure, the insurance company, association or exchange shall transfer from the insurance proceeds to the designated officer of the municipality in the aggregate two thousand dollars ($2,000) for each fifteen thousand dollars ($15,000) and each fraction of that amount of a claim, or, if at the time of a loss report the named insured has submitted a contractor's signed estimate of the costs of removing, repairing or securing the building or other structure in an amount less than the amount calculated under the foregoing transfer formula, the insurance company, association or exchange shall transfer from the insurance proceeds the amount specified in the estimate. The transfer of proceeds shall be on a pro rata basis by all companies, associations or exchanges insuring the building or other structure. Policy proceeds remaining after the transfer to the municipality shall be disbursed in accordance with the policy terms. The named insured may submit a contractor's signed estimate of the costs of removing, repairing or securing the building or other structure after the transfer, and the designated officer shall return the amount of the fund in excess of the estimate to the named insured if the municipality has not commenced to remove, repair or secure the building or other structure. This subsection only applies to municipalities that have adopted an ordinance authorizing the procedure described in subsections (c) and (d) of this section and applies only to fire losses that occur after the adoption of the ordinance. The ordinance shall designate the officer authorized to carry out the duties of this section.

(d) Upon receipt of proceeds by the municipality as authorized by this section, the designated officer shall place the proceeds in a separate fund to be used solely as security against the total cost of removing, repairing or securing incurred by the municipality. When transferring the funds as required in subsection (c) of this section, an insurance company, association or exchange shall provide the municipality with the name and address of the named insured, whereupon the municipality shall contact the named insured, certify that the proceeds have been received by the municipality and notify the named insured that the procedures under this subsection shall be followed. The fund shall be returned to the named insured when repairs, removal or securing of the building or other structure have been completed and the required proof received by the designated officer if the municipality has not incurred
any costs for repairs, removal or securing. If the municipality has incurred costs for repairs, removal or securing of the building or other structure, the costs shall be paid from the fund, and, if excess funds remain, the municipality shall transfer the remaining funds to the named insured. Nothing in this section shall be construed to limit the ability of a municipality to recover any deficiency. Further, nothing in this subsection shall be construed to prohibit the municipality and the named insured from entering into an agreement that permits the transfer of funds to the named insured if some other reasonable disposition of the damaged property has been negotiated.

(e) Proof of payment by the insurance company, association or exchange of proceeds under a policy in accordance with subsection (c) of this section is conclusive evidence of the discharge of its obligation to the insured under the policy to the extent of the payment and of compliance by the company, association or exchange with subsection (c) of this section.

(f) Nothing in this section shall be construed to make an insurance company, association or exchange liable for any amount in excess of proceeds payable under its insurance policy or for any other act performed pursuant to this section or to make a municipality or public official an insured under a policy of insurance or to create an obligation to pay delinquent property taxes or unpaid removal liens or expenses other than as provided in this section.

(g) An insurance company, association or exchange making payments of policy proceeds under this section for delinquent taxes or structure removal liens or removal expenses incurred by a municipality shall have a full benefit of such payment, including all rights of subrogation and of assignment.

(h) Subsections (a) and (b) of this section shall apply only to municipalities that have adopted an ordinance authorizing the procedure set forth in subsections (a) and (b) and only to fire losses that occur after the effective date of the ordinance.

(i) When an ordinance is first passed or adopted by a municipality under subsections (a) and (b) of this section or subsections (c) and (d) of this section, or both, an exact copy of the ordinance shall be filed with the Department of Community Affairs, together with the name, position and phone number of the municipal official responsible for compliance with this section. Each municipality enacting an ordinance under this section shall supply the information required by this subsection to the Department of Community Affairs as part of the implementation of its ordinance. The Department of Community Affairs shall periodically produce a register listing those municipalities filing the ordinance. This register shall be made available to insurance companies at minimum cost. An insurance company, association or exchange shall not be required to comply with any municipal ordinance if the municipality fails to provide a copy of the ordinance to the Department of Community Affairs.

(j) The term "municipality," as used in this section, shall mean any city, borough, town, township or home rule municipality. The term "treasurer," as used in this section, shall mean an elected treasurer or other appropriate municipal officer authorized to collect real property taxes.

(k) This section shall be liberally construed to accomplish its purpose to deter the commission of arson and related crimes, to discourage the abandonment of property and to prevent urban blight and deterioration.
(b) PROVISIONS RELATING TO STOCK COMPANIES.

Section 516. Capital of Foreign Companies.--Stock fire, stock marine, and stock fire and marine insurance companies, of other States and foreign governments, to be licensed to do, in this Commonwealth, any one of the classes of business mentioned in section two hundred and two (202), subdivision (b) of this act, must have a paid up and safely invested capital and surplus, if a company of any other State, or a deposit in the United States, if a company of a foreign government, of not less than that required of domestic insurers to be authorized to transact the class or classes of business.


Section 518A. Estimation of Surplus for the Purpose of Making Dividends.--(518A repealed Feb. 17, 1994, P.L.92, No.9)

Section 518B. Investment Regulations.--(a) Any domestic company may invest its funds in sound investments as provided in this act and not otherwise. Notwithstanding the provisions of this act, the Insurance Commissioner may, after notice and hearing, order a domestic company to limit or withdraw from certain investments, or discontinue certain investment practices, to the extent that the Insurance Commissioner finds that such investments or investment practices are unsound or may endanger the solvency of the company. The investments of a foreign company shall be as permitted by the investment laws of its state of domicile if such laws are substantially similar to that provided by this act. No investment or loan or an investment practice shall be made or engaged in by any domestic company unless the same has been authorized or ratified by the board of directors or by a committee thereof charged with the duty of supervising investments and loans. No such company shall subscribe to or participate in any underwriting of the purchase or sale of securities or property or enter into any agreement to withhold from sale any of its property, but the disposition of its property shall be at all times within the control of the board of directors. Any agreement or contract providing for the lawful disposition of property wherein such disposition may be determined at the option of a third person at some specified future price or condition or specified time or upon demand shall be construed to be within the control of the board of directors. Nothing contained in this section shall prevent the board of directors of any such company from depositing any of its securities with a committee appointed for the purpose of protecting the interest of security holders or with authorities of any state or country where it is necessary to do so in order to secure permission to transact its appropriate business therein; and nothing contained in this section shall prevent the board of directors of such company from depositing securities as collateral for the securing of any bond required for the business of the company.

(b) Any domestic company subject to the provisions of this act is required to have a formal investment plan which shall be updated on an annual basis as authorized by the board of directors. The investment plan shall include, at a minimum, a description of the investment strategy of the company designed to provide for liquidity and diversity of the investment
portfolio. The investment plan, and such other information as
the Insurance Department may require in order to determine the
impact of the investment plan on the solvency of the company,
shall be made available to the Insurance Department during the
course of a financial condition examination conducted in
accordance with the laws pertaining to the conduct of
examinations.


Section 518C. Eligible Investments.--(a) Every domestic
stock fire, stock marine or stock fire and marine insurance
company shall invest and keep invested all its funds in sound
investments enumerated below, except such cash as may be
required in the transaction of its business. Such investments
shall include:

(1) Bonds, notes or obligations issued, assumed, guaranteed
or insured by the United States, or by any state, territory or
possession thereof, the District of Columbia or by any county,
city, town, village, municipality or district therein or by any
political subdivision or public instrumentality of one or more
of the foregoing, or by any foreign country or political
subdivision thereof.

(2) Bonds, notes, obligations or stock, issued, assumed,
guaranteed or insured by the following agencies of the United
States or in which such government is a participant, whether
or not such obligations are guaranteed by such government:
(i) Farm Loan Bank.
(ii) Commodity Credit Corporation.
(iii) Federal intermediate credit banks.
(iv) Federal land banks.
(v) Central bank for cooperatives.
(vi) Federal home loan banks and stock thereof.
(vii) Federal National Mortgage Association and stock
thereof.
(viii) International Bank for Reconstruction and
Development.
(ix) Inter-American Development Bank.
(x) Asian Development Bank.
(xi) African Development Bank.
(xii) Any other similar agency of, or in which there is
participation by, the government of the United States, and the
instruments are of similar financial quality.

(3) Bonds, notes, obligations or other investments of or
in any business unit in or of any foreign country which are of
the same kinds, classes and grades as those eligible for
investment under this subsection. The cost of investments under
this clause shall not exceed thirty percentum (30%) of such
company's admitted assets.

(4) Business obligations and equity interests:
(i) Stock, warrants, rights or other security, bonds, notes
or obligations issued, assumed, guaranteed, insured or accepted
by any solvent corporation, joint-stock association, business
trust, business partnership, business joint venture or other
business entity or combination thereof incorporated or existing
under the laws of the United States or of any state, district
or territory thereof, and any interest in any of the foregoing:
Provided, That no domestic company shall invest in any general
partnership but may become a limited partner in a partnership
in any investment on the following conditions:
(A) the partnership must be organized under the Limited
Partnership Act of the state of the partnership formation;
(B) a company may not invest more than ten percentum (10%)
of its capital and surplus in any one such partnership; and
(C) the aggregate cost of investment in limited partnerships shall not exceed ten percentum (10%) of the company's admitted assets.

(ii) Interest-bearing deposits, or certificates of deposit in banks, bank and trust companies, savings banks, savings associations, savings and loan associations or national banking associations, incorporated or existing under the laws of the United States or any state, district or territory thereof, including branches of any of the foregoing, or foreign banking institutions or branches thereof located in the United States or any state, district or territory thereof: Provided, That investments under this clause in interest-bearing deposits and certificates of deposit issued by institutions incorporated under foreign law, exclusive of such deposits and certificates issued by branches of such institutions located in the United States or any state, district or territory thereof, shall be limited to twenty percentum (20%) of such company's assets, such investments qualifying in addition to those authorized by clause (3).

(iii) Obligations which are not issued, assumed, guaranteed or accepted by any person described under subclause (i), but are adequately secured by an assignment of a right to receive rent, purchase or other payment or revenues, for the use or purchase of real or personal property sufficient to repay the investment, and payable or guaranteed by any one or more persons or entities whose bonds, notes or obligations would qualify for investment under this clause or a mortgage, interest in a mortgage pool or mortgage participation or lien or security interest in real or personal property or any interest therein.

(5) Obligations or participations therein, secured by liens on real property or interests therein: Provided, That the value of such real property or interest therein, together with such other security as shall secure any such obligation, shall be adequate to secure the investment as well as any lien senior to the lien created by the investment in such real estate. No investment in a single transaction shall exceed an amount equal to five percentum (5%) of such company's admitted assets.

(6) Such real estate or interests therein as it is authorized by this act to hold.

(7) Tangible personal property or fixtures or interest therein, however evidenced, as an investment for the production of income. Investments under this clause shall not exceed fifteen per centum (15%) of the company's admitted assets. (((7) amended Dec. 18, 1992, P.L.1519, No.178)

(8) The investment practice of financial futures contracts issued under terms and conditions regulated by a Federal regulatory agency is authorized on the following conditions:

(i) A company shall not enter into financial futures contracts except as a hedging transaction as that term is defined in a rule or regulation promulgated pursuant to this act.

(ii) A company shall not have initial or maintenance margin outstanding under this clause of more than ten percentum (10%) of the excess of its capital and surplus over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the company is authorized to write.

(iii) The Insurance Commissioner may promulgate reasonable rules and regulations for transactions under this clause to include, but not limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.
(9) Put options and call options. The investment practice of put options and call options issued under terms and conditions regulated by, or substantially similar to those terms and conditions required by, a national securities exchange registered under the Securities Exchange Act of 1934 (48 Stat. 881, 15 U.S.C. § 78a et seq.), as amended, or any board of trade designated as a contract market by the Commodity Futures Trading Commission (CFTC) under the Commodity Exchange Act (49 Stat. 1491), as amended, is authorized on the following conditions:

(i) a company shall not sell a call option on either (A) securities it does not own or (B) in an amount greater than securities which it presently owns: Provided, however, That in the case of financial futures contracts and stock or bond index contracts where it is not feasible to own the underlying security, a company may sell a call option only in connection with a hedging transaction;

(ii) a company shall not sell a put option unless its obligations under such put option are fully secured by a deposit by the company with a bank or other custodian of cash or cash equivalents;

(iii) a company shall not purchase as opening transactions under this clause more than ten percentum (10%) of the excess of its capital and surplus over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the company is authorized to write; and

(iv) the Insurance Commissioner may promulgate reasonable rules and regulations for transactions under this clause to include, but not be limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.

(10) Options or futures contracts traded in markets regulated under the laws of the United States or by an agency thereof and other contracts or instruments for the purpose of reducing the insurer's economic risk in connection with potential changes in the value of specifically identified assets which the insurer owns or could reasonably expect to acquire or specifically identified liabilities which the insurer has or reasonably expects to incur. The aggregate cost of investments held under this clause shall not exceed five percentum (5%) of the company's admitted assets. The Insurance Commissioner shall promulgate reasonable rules and regulations for transactions under this clause to include, but not limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.

(11) Lending of securities, repurchase agreements and reverse repurchase agreements.

(i) Definitions:

(A) "Lending of securities" means an investment other than a repurchase agreement, whereby an agreement is entered into which transfers ownership rights and possession of securities to the borrower of such securities with the agreement providing for a return of ownership rights and possession of the securities to the lender at a specified date or upon demand.

(B) "Repurchase agreement" means a bilateral agreement whereby a company purchases securities with a related agreement that the seller will purchase or repurchase at a specified price the equivalent or similar securities within a specified period of time or on demand.

(C) "Reverse repurchase agreement" means a bilateral agreement whereby a company (I) sells securities with a related agreement to purchase or repurchase at a specified price the
equivalent or similar securities within a specified period of time or upon demand or (II) borrows funds and transfers securities to the lender with a related agreement that equivalent or similar securities will be returned to the company upon repayment of the loan within a specified period of time or on demand.

(ii) Lending of securities, repurchase agreements and reverse repurchase agreements transactions are authorized on the following conditions:

(A) The agreement for each transaction or the master agreement for a series of transactions shall be reduced to writing.

(B) Securities acquired by a company owned subject to reacquisition pursuant to an outstanding repurchase agreement may not be sold pursuant to a reverse repurchase agreement nor lent pursuant to a lending of securities agreement. Consideration, or collateral, received from a reverse repurchase agreement or lending of securities agreement may be used to acquire securities which are equivalent or similar to the securities transferred pursuant to such repurchase agreement or lending of securities agreement; however, such acquired securities may not be sold pursuant to a reverse repurchase agreement nor lent pursuant to a lending of securities agreement.

(C) A company is limited to no more than five percentum (5%) of its admitted assets being subject to lending of securities, repurchase agreements or reverse repurchase agreements transactions outstanding with any one business entity under this section.

(D) A company may engage in lending its securities or repurchase or reverse repurchase agreements up to forty percentum (40%) of its admitted assets: Provided, however, That such transactions are fully collateralized.

(E) The Insurance Commissioner may promulgate reasonable rules and regulations for investments and transactions under this section to include, but not be limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.

((ii) amended Nov. 30, 2004, P.L.1690, No.216)

(12) Other loans and investments:

(i) Loans or investments not authorized by any of the clauses of this section, to an amount not exceeding the aggregate of twenty percentum (20%) of such company's admitted assets. The twenty percentum (20%) limitation provided above shall be increased in the same amount that investments approved by the Insurance Commissioner are made in the following categories of investments provided that their principal operations or locations are located in this Commonwealth:

(A) Investments in venture capital limited partnerships or in new and young small businesses which are making an initial public offering of securities or utilizing a limited private placement.

(B) Investments in minority-owned-and-operated businesses as domiciles in Pennsylvania, as provided in the act of July 22, 1974 (P.L.598, No.206), known as the "Pennsylvania Minority Business Development Authority Act."

(C) Investments in businesses located in enterprise zones designated by the Department of Community Affairs.

(D) Investments in housing for families and persons of low income or in housing in enterprise zones designated by the Department of Community Affairs.
(E) Investments in seed capital funds established pursuant to the provisions of the act of July 2, 1984 (P.L.555, No.111), known as the "Small Business Incubators Act."

(F) Investments in business development credit corporations established pursuant to the act of December 1, 1959 (P.L.1647, No.606), known as the "Business Development Credit Corporation Law."

(G) Investments in small business investment corporations and minority enterprise small business investment companies certified pursuant to applicable Federal laws. However, in no event may the percentage limitation under this clause exceed the aggregate of twenty-five percentum (25%).

(ii) For each one-half percentum (.5%) of such company's admitted assets invested in categories (A) through (G) of subclause (i) of this clause whose principal operations or locations are located in this Commonwealth, investments under other clauses of this section may exceed the volume limitations set forth in such other clauses by an aggregate of two and one-half percentum (2.5%) of the company's admitted assets, but in no event may such excess investments exceed a maximum of five percentum (5%) of admitted assets; however, such excess investments shall be charged against the limitation established in subclause (i) of this clause.

(iii) The Insurance Commissioner shall promulgate reasonable rules and regulations for transactions under this clause, to include, but not limited to, rules and regulations which impose financial solvency standards, valuation standards and reporting requirements.

(b) No such company shall lend any of its funds on personal security except a loan for defraying, in whole or in part, the expenses of an employe transferred or about to be transferred to a new place of employment with such company.

(c) Any such company may, with the approval of its board of directors, acquire, retain, cancel or dispose of shares of its own capital stock, provided that:

(1) No such company shall acquire such stock without the prior approval of the Insurance Commissioner.

(2) No such company shall effect a reduction in its capital stock without complying with the applicable provisions of law.

(3) No such company shall directly or indirectly vote shares of its own stock held by it.


Section 518D. Valuation of Investments.--(a) Investments shall be valued in accordance with the published valuation standards of the National Association of Insurance Commissioners. Securities investments as to which the National Association of Insurance Commissioners has not published valuation standards in its valuation of securities manual or its successor publication shall be valued as follows:

(1) Any investment by any insurer that is not valued by standards published by the National Association of Insurance Commissioners shall, at the time of acquisition, be submitted to the National Association of Insurance Commissioners for evaluation.

(2) Other securities investments shall be valued in accordance with regulations promulgated by the Insurance Commissioner pursuant to subsection (d) of this section.

(b) Other investments, including real property, shall be valued in accordance with regulations promulgated by the Insurance Commissioner pursuant to subsection (d) of this section, but in no event shall such other investments be valued at more than their purchase price. Purchase price for real
property includes capitalized permanent improvements, less depreciation spread evenly over the life of the property or, at the option of the company, less depreciation computed on any basis permitted under the United States Internal Revenue Code of 1954 (68A Stat. 3, 26 U.S.C. § 1 et seq.) and regulations thereunder. Such investments that have been affected by an impairment, other than a temporary decline, in value shall be valued at not more than their market value. ((b) amended Dec. 18, 1992, P.L.1519, No.178)

(c) Any investment, including real property, not purchased by a company but acquired in satisfaction of a debt or otherwise shall be valued in accordance with the accounting procedures and practices developed by the National Association of Insurance Commissioners as required by the law relating to the filing of annual financial statement blanks. ((c) amended Dec. 18, 1992, P.L.1519, No.178)

(d) The Insurance Commissioner may promulgate rules and regulations for determining and calculating values to be used in financial statements submitted to the department for investments not subject to published National Association of Insurance Commissioners' valuation standards.

(e) The eligibility of an investment shall be determined as of the date of its making or acquisition or the date of commitment in the case of commitment to invest.

(f) If any investment is made in an investment not permitted or in a manner not authorized by this act, the officers, directors and trustees making or authorizing such investment shall be personally liable for any loss occasioned thereby.

(g) Nothing in this act shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or upon a debt or judgment, or under a lawful and bona fide agreement of bulk reinsurance, merger or consolidation, or if acquired by it through the exercise of warrants, options or similar rights to acquire securities received by it in accordance with this act. Nothing in this act shall prevent any insurer from entering into an agreement for the purpose of protecting the interests of the insurer in securities lawfully held by it, or for the purpose of reorganization of a corporation which issued securities so held, and from depositing such securities with a committee or depositaries appointed under such agreement, nor from accepting stock, bonds or other securities or other property which may be distributed pursuant to any such agreement, or to any plan of reorganization or arrangement; and no provision of this act shall prevent any insurer from acquiring or holding any property acquired in satisfaction of any debt previously contracted, or that shall be obtained by sale or foreclosure of any security held by it. Any security or property so acquired which is not otherwise an eligible investment under this act shall be disposed of within five (5) years from date of acquisition, unless within such period the security or property has attained to the standard of eligibility, except that any security or personal property acquired under any agreement of bulk reinsurance, merger or consolidation may be retained for a longer period if so provided in the plan for such reinsurance, merger or consolidation. The commissioner may grant from time to time reasonable extensions of the period within which an insurer shall dispose of any such property or security.


Section 519. Real Estate Which May Be Acquired, Held, and Conveyed.—A domestic stock fire, stock marine, or stock fire
and marine insurance company may, directly or indirectly, alone
or in combination with one or more other persons or entities
(except that no domestic stock fire, stock marine, or stock
fire and marine insurance company may participate in a general
partnership), acquire by purchase, lease or otherwise or
receive, hold, or convey real estate, or any interest therein:
(a) Required for its convenient accommodation in the
transaction of its business, including residential real estate
purchased from employees transferred or about to be transferred
to new places of employment with such company.
(b) Conveyed to it in satisfaction of debts previously
contracted in the course of its dealing.
(c) Purchased at sales upon judgments, decrees, or
mortgages, obtained or made for debts due the company, or for
debts due other persons where said company may have liens or
encumbrances on the same, and the purchase is deemed necessary
to save the company from loss.
(d) Reasonably necessary for the purpose of maintaining or
enhancing the sale value of real property previously acquired
or held by it under subsection (a), (b), (c) or (e).
(e) As an investment for the production of income or capital
appreciation, or so acquired for development, improvement,
maintenance or construction and maintenance for such investment
purposes, provided that the aggregate cost of investments in
unimproved real estate under this subsection shall not exceed
the lesser of ten per centum (10%) of the company's admitted
assets or forty-five per centum (45%) of its capital and
surplus. ((e) amended Dec. 18, 1992, P.L.1519, No.178)
Section 519.1. Additional Investment Authority for
Subsidiaries.--(a) As used in this section the following words
and phrases shall have the meanings given to them in this
subsection:
"Insurance company" or "insurer" includes any company,
association or exchange authorized to conduct an insurance
business in the jurisdiction of its domicile.
"NAIC" means the National Association of Insurance
Commissioners.
"Owner" or "holder" of securities of a specified person is
one who owns any security of such person, including common
stock, preferred stock, debt obligations and any other security
convertible into or evidencing the right to acquire any of the
foregoing.
"Person" is an individual, corporation, partnership,
association, joint-stock company, business trust, unincorporated
organization, any similar entity or any combination of the
foregoing acting in concert.
"Subsidiary" shall mean only a corporation in which another
person owns or holds, with the power to vote directly or through
one or more intermediaries, a majority of the outstanding voting
securities. A person whose business consists primarily of real
property and interests therein shall not be deemed a subsidiary
for the purposes of determining the volume limitations set forth
in clause (1) of subsection (c). A person which is controlled
by another person solely as a result of the temporary assumption
of control by the owner of securities upon the happening of a
prescribed event of default shall not be deemed a subsidiary
or affiliate for purposes of this section, if such securities
are disposed of within five (5) years from the date of
acquisition, unless such period is extended by the Insurance
Commissioner to enable the owner to dispose of such securities
in a reasonable and orderly manner.
"Voting security" means stock of any class or any ownership interest having the power to elect the directors, trustees or management of a person, other than securities having such power only by reason of the happening of a contingency.

(b) Any domestic stock fire, stock marine or stock fire and marine insurance company, either by itself or in cooperation with one or more persons, may, in addition to any authority to acquire or hold securities in corporations provided for elsewhere in this act, organize or acquire one or more subsidiaries. Such subsidiaries may conduct any kind of business or businesses, and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic stock fire, stock marine or stock fire and marine insurance company. No domestic stock fire, stock marine or stock fire and marine insurance company shall be deemed to be authorized to participate in or to form a general partnership with any other person.

(c) (1) At no time shall a domestic stock fire, stock marine or stock fire and marine insurance company make an investment in any subsidiary which will bring the aggregate value of its investments, as determined for annual statement purposes but not in excess of cost, in all subsidiaries under this subsection to an amount in excess of ten per centum (10%) of its total admitted assets as of the immediately preceding thirty-first day of December. In determining the amount of investments of any domestic stock fire, stock marine or stock fire and marine insurance company in subsidiaries for purposes of this subsection, there shall be included investments made directly by such insurance company and, if such investment is made by another subsidiary, then to the extent that funds for such investments are provided by the insurance company for such purpose. ((1) amended Feb. 17, 1994, P.L.92, No.9)

(2) The limitations set forth in clause (1) of this subsection shall not apply to investments in any subsidiary which is:

(i) An insurance company.

(ii) A holding company to the extent its business consists of the holding of the stock of or otherwise controlling its own subsidiaries.

(iii) A corporation whose business primarily consists of direct or indirect ownership, operation or management of assets authorized as investments pursuant to sections 518C and 519.

(iv) A company engaged in any combination of the activities described in subclauses (i), (ii) and (iii) of this clause. Investments made pursuant to subclause (i) shall not be restricted in amount provided that after such investment, as calculated for NAIC annual statement purposes, the insurer's surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. Investments made pursuant to subclause (ii), or to the extent applicable in this subclause, shall in addition not be subject to any limitations on the amount of a domestic stock fire, stock marine or stock fire and marine insurance company's assets provided for under any other provision of this act and which might otherwise be applicable: Provided, however, That such stock fire, stock marine or stock fire and marine insurance company's investments, to the extent that such stock fire, stock marine or stock fire and marine insurance company provided the funds therefor, in each of the subsidiaries of such holding company shall be subject to the limitations, if any, applicable to such investment as if the holding company's interest in each such subsidiary were instead owned directly by the stock fire,
stock marine or stock fire and marine insurance company. Investments made pursuant to subclause (iii) or, to the extent applicable, this subclause shall be counted in determining the limitations contained in applicable subsections of sections 518C and 519: Provided, however, That the value as calculated for annual statement purposes, but not in excess of the cost thereof, of such investment shall include only funds provided by the insurance company therefor. Investments made in other subsidiaries of such stock fire, stock marine or stock fire and marine insurance company by any subsidiary described in subclauses (i), (ii), (iii) and this subclause or by a person whose business primarily consists of direct or indirect ownership, operation or management of real property and interest therein under section 519 shall be deemed investments made by the insurance company only to the extent the funds for such investment were provided by such insurance company.

(d) No restrictions, prohibitions or limitations contained in this act otherwise applicable to investments of domestic stock fire, stock marine or stock fire and marine insurers shall be applicable to investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (c); nor shall the additional investment authority granted by said subsection (c) have the effect of restricting, prohibiting or limiting the rights of a domestic stock fire, stock marine or stock fire and marine insurer to make investments permitted under any other section of this act.

(e) Whether any investment made pursuant to subsection (c) meets, at any time thereafter, the applicable requirements thereof is to be determined when such investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value, but not in excess of the cost thereof, of all previous investments in equity securities as calculated for annual statement purposes. In calculating the amount of such investments, there shall be included, as determined for NAIC annual statement purposes:

1. Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

2. All amounts expended by the domestic stock fire, stock marine or stock fire and marine insurance company in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus, or a subsidiary subsequent to its acquisition or formation.

(f) If a domestic stock fire, stock marine or stock fire and marine insurer ceases to own, directly or indirectly through one or more intermediaries, a majority of the voting securities of a subsidiary held pursuant to subsection (c), it shall dispose of any investment therein made pursuant to such subsection within five (5) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless, at any time after such investment shall have been made, such investment shall have met the requirements for investment under any other section of this act.

(519.1 added Dec. 18, 1992, P.L.1519, No.178)

Section 520. Procedure When Capital Impaired.—Any stock fire, stock marine, and stock fire and marine insurance company, receiving notice from the Insurance Commissioner that its capital is impaired, shall immediately call upon its
stockholders for such amounts as will restore its capital to the amount fixed by its charter. In case any stockholder neglects or refuses to pay the amount called for, after notice personally given or by advertisement, at such time and in such manner as the commissioner shall approve, the company shall require the return of the original certificate of stock held by such stockholder, and, in lieu thereof, issue new certificates in the proportion that the ascertained value of the assets of the company may, as determined by the commissioner, bear to the original capital, the company paying for any fractional parts of shares. The directors may create new stock and issue certificates therefor, and dispose of the same, at not less than par, for an amount sufficient to make up the original capital. Or the commissioner may, in his discretion, permit the company to reduce its capital and the par value of its shares in proportion to the extent of the impairment, but the capital shall at no time be reduced to an amount less than that required by law for the organization of any such company. In fixing such reduced capital, not more than fifty per centum (50%) of the original capital shall be deducted from the assets on hand to be retained as surplus funds, nor shall any part of the assets be distributed to stockholders.

Section 521. Joint Policies.--(521 repealed July 19, 1951, P.L.1100, No.245)


(c) PROVISIONS RELATING TO MUTUAL COMPANIES.

Section 531. Licensing of Foreign Mutual Companies.--(a) A mutual fire, mutual marine, or mutual fire and marine insurance company of another State which had been originally licensed to transact business in this Commonwealth prior to and was transacting business in this Commonwealth on June twenty-third, one thousand nine hundred and thirty-one, may be relicensed to transact the class of business mentioned in clause (1) subdivision (b) of section two hundred and two (202) of this act when it has a surplus over all liabilities, including unearned premiums, computed in accordance with the laws of this Commonwealth of not less than one hundred thousand dollars ($100,000), or has continuously transacted business for not less than five years and has a surplus over all liabilities of not less than fifty thousand dollars ($50,000). If to transact the classes of business mentioned in clauses (2) and (3) of subdivision (b), section two hundred and two (202) of this act, its surplus over all liabilities must not be less than two hundred and fifty thousand dollars ($250,000).

(b) A mutual fire, mutual marine, or mutual fire and marine insurance company of another state, which had not been originally licensed to transact business in this Commonwealth prior to and was not transacting business in this Commonwealth on June twenty-third, one thousand nine hundred and thirty-one, may be licensed and relicensed to transact the class of business mentioned in clause (1) subdivision (b), of section two hundred and two (202) of this act, when it has a surplus over all liabilities, including unearned premiums, computed in accordance with the laws of this Commonwealth of not less than one hundred and fifty thousand dollars ($150,000). If to transact the
classes of business mentioned (i) in either clause (2) or clause (3) of said subdivision, (b), when it has such a surplus of not less than two hundred thousand dollars ($200,000); (ii) in said clause (1) and in either of said clauses (2) or (3), when it has such a surplus of not less than three hundred fifty thousand dollars ($350,000); (iii) in both of said clauses (2) and (3), when it has such a surplus of not less than four hundred thousand dollars ($400,000); and (iv) in all of said clauses (1, (2) and (3), when it has such a surplus of not less than five hundred fifty thousand dollars ($550,000). ((b) amended July 19, 1951, P.L.1100, No.245)

(531 amended Apr. 4, 1935, P.L.13, No.9)

Section 532. Rechartering of Companies.--(532 repealed Dec. 19, 1990, P.L.834, No.198)

Section 533. Reinsurance and Reserve of Companies Organized Before May First, One Thousand Eight Hundred and Seventy-six.--(533 repealed Dec. 3, 1975, P.L.473, No.138)

Section 534. Mutual Companies Organized Prior to May First, One Thousand Eight Hundred and Seventy-six May Become Stock Companies.--(534 repealed May 13, 1949, P.L.1318, No.389)

(d) FIRE INSURANCE RATES AND RATING BUREAUS.

Section 541. "Insurer" Defined.--(541 repealed June 11, 1947, P.L.551, No.247)

Section 542. Insurers To File Schedule of Rates or Be Members of Rating Bureaus.--(542 repealed June 11, 1947, P.L.551, No.247)

Section 543. Membership of Rating Bureau; Expenses.--(543 repealed June 11, 1947, P.L.551, No.247)

Section 544. Insurers To Notify Department of Rating Bureaus of Which Members.--(544 repealed June 11, 1947, P.L.551, No.247)

Section 545. Variations from Bureau Rates.--(545 repealed June 11, 1947, P.L.551, No.247)


Section 547. Inspection of Risks.--(547 repealed June 11, 1947, P.L.551, No.247)


Section 549. When Rate Agreement May Be Enforced.--(549 repealed June 11, 1947, P.L.551, No.247)

Section 550. Insurance Commissioner May Disapprove Rate Agreements; Procedure.--(550 repealed June 11, 1947, P.L.551, No.247)

Section 551. Prohibited Contracts and Agreements.--(551 repealed June 11, 1947, P.L.551, No.247)

Section 552. Rating Bureaus To Supply Department of State Police with Information.--(552 repealed June 11, 1947, P.L.551, No.247)


ARTICLE V-A.
PROPERTY AND CASUALTY FILING REFORM.

Compiler's Note: Section 13 of Act 150 of 1998, which added Article V-A, provided that Article V-A shall apply to all forms issued or rates used after the effective date of Article V-A.
Section 501-A. Short Title of Article.--This article shall be known and may be cited as the Property and Casualty Filing Reform Act.

Section 502-A. Purpose.--The purposes of this article are to:
(1) Protect policyholders and the public from excessive, inadequate or discriminatory rates.
(2) Promote price competition and improve the availability and reliability of insurance.
(3) Encourage efficient and economical marketing practices.
(4) Ensure availability of price and related information to consumers.
(5) This article shall supercede section 354 to the extent that section 354 is to the contrary.

Section 503-A. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Association." Individuals, partnerships or associations of individuals authorized to engage in the business of insurance on the Lloyds plan.

"Classification." The process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Company." The term includes insurance companies as defined in section 101 and title insurance companies, whether incorporated under the laws of this Commonwealth or any other state, territory or district or under the laws of any foreign country.

"Department." The Insurance Department of the Commonwealth.

"Exchange." The term includes individuals, partnerships and corporations authorized to exchange with each other interinsurance or reciprocal insurance contracts.

"Expenses." The portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees.

"Filing." A form or rate filing required by section 505-A.

"Form." A policy, contract, certificate, evidence of coverage, application, rider or endorsement affording insurance coverage or benefit against loss.

"Insurer." A licensed company, exchange or association as defined in section 101 or a rating organization licensed under section 512-A.

"Joint underwriting." A voluntary agreement established to provide insurance coverage for a risk in which two (2) or more insurers jointly contract with the insured at a price and under policy terms agreed upon by the insurers.

"Large commercial risk." A risk of a commercial entity, that is not a personal risk, whose aggregate annual property and casualty premiums on all policies, excluding workers' compensation, total at least twenty-five thousand dollars ($25,000) or which has at least twenty-five (25) full-time employees at the time the policy is written or renewed, and for which the entity uses an employee acting as an insurance manager or buyer or a retained qualified insurance consultant or risk manager provided the insurance is procured in accordance with the laws of this Commonwealth.
"Loss adjustment expense." The expenses incurred by the insurer in the course of settling claims.

"Marine and inland marine insurance." Insurance defined by general custom of the business as inland marine insurance or as otherwise defined by law or ruling of the Insurance Commissioner.

"Personal risks." Personal automobile risks as defined in the act of June 5, 1968 (P.L.140, No.78), entitled "An act regulating the writing, cancellation of or refusal to renew policies of automobile insurance; and imposing powers and duties on the Insurance Commissioner therefor," and personal property risks described in the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

"Rate." The cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of expenses, profit and individual insurer variation in loss experience prior to any application of individual risk variations based on loss or expense considerations. The term does not include minimum premium. The term also includes supplementary rating information.

"Small commercial risks." A risk of a commercial entity which does not qualify as a large commercial risk.

"Statistical plan." The plan, system or arrangement used in collecting data.

"Supplementary rating information." A manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule and other similar information necessary to determine an applicable rate.


Section 504-A. Scope.--(a) This article shall apply to property and casualty insurance, including fidelity, surety and guaranty bond and fire insurance, inland marine insurance and any combination thereof, on risks or operations located in this Commonwealth.

(b) This article shall not apply to any of the following:

(1) Reinsurance other than statutorily authorized joint reinsurance mechanisms.

(2) Insurance on vessels or crafts, their cargoes, marine builders' risk, marine protection and indemnity or other risks commonly insured under marine insurance policies.

(3) Insurance on hulls of aircraft, including their accessories and equipment, or against liability arising out of the ownership, maintenance or use of aircraft.

(4) Personal risks.

(5) Accident and health insurance.

(6) Title insurance.

(7) Workers' compensation insurance.

(8) Insurance covering loss in excess of at least ten thousand dollars ($10,000) from any one event issued to self-insurers. The amount may be changed by department regulation.

(504-A added Dec. 21, 1998, P.L.1108, No.150)

Section 505-A. Required Rate and Form Filings.--(a) All forms and rates used by an insurer shall be filed with the department unless otherwise provided in subsections (b), (c) and (d).

(b) The commissioner may publish notice in the Pennsylvania Bulletin of any type of form which is exempted from filing. The commissioner may revoke an exemption by publishing notice in the Pennsylvania Bulletin. Revocation shall take effect ninety (90) days following publication.
(c) (1) Forms for small commercial risks shall be filed with the department no later than forty-five (45) days prior to their effective date. Filings under this section shall be available for use forty-five (45) days after filing, or after a comment period established by the commissioner, unless earlier approved or disapproved by the commissioner.

(2) An insurer shall file rates under this subsection for small commercial risks with the department as follows:

(i) Insurers shall establish an initial base rate for existing lines of business which is not excessive, inadequate or unfairly discriminatory. The initial base rate shall be the rate currently on file and approved by the department on the effective date of this article. The initial base rate for any line of business which is not on file and which has not been approved on the effective date of this article shall be subject to filing, review and prior approval by the department.

(ii) If proposed changes to an approved base rate will increase or decrease the approved base rate by more than ten per centum (10%) annually in the aggregate, the changes shall be subject to filing, review and prior approval by the department.

(iii) If proposed changes to an approved base rate will increase or decrease the approved base rate by ten per centum (10%) or less annually in the aggregate, the changes shall be filed with the department no later than forty-five (45) days prior to their effective date. Filings under this section shall be available for use forty-five (45) days after filing, or after a comment period established by the commissioner, unless earlier approved or disapproved by the commissioner.

(iv) Rate filings reviewed under subparagraphs (i) and (ii) shall be available for use forty-five (45) days after filing, or at the end of any public comment period established by the commissioner under section 507-A(a), unless earlier approved or disapproved by the commissioner. The commissioner may extend the forty-five-day approval period for an additional forty-five (45) days by written notice to the insurer.

(v) Individual filings shall not be required for a specific individual policy if the rate does not deviate from the base rate by more than twenty-five per centum (25%).

(vi) Rates developed for individual insureds which deviate from the base rate by more than twenty-five per centum (25%) may be used immediately and shall be filed with the department no later than thirty (30) days after the effective date of the rate.

(vii) The commissioner may exempt a rate filing required under this section by publishing a notice in the Pennsylvania Bulletin identifying the type or kind of rate being exempted, to include rates which in the opinion of the commissioner would be impractical to file prior to use. The commissioner may subsequently require exempted rates to be filed by publishing notice of the requirement in the Pennsylvania Bulletin. The subsequent notice shall be effective in ninety (90) days.

(d) The commissioner may evaluate and adjust the restrictions on premium limits and the number of employees of a large commercial risk by regulation. Insurers shall not be required to file forms or rates for large commercial risks with the department in the case of a large commercial risk located in this Commonwealth. If after holding a hearing the commissioner determines that the market is noncompetitive, an order shall be issued to require rate filings for large commercial risks. The commissioner shall consider all relevant factors to determine competitiveness of the market, to include
the number of insurers actively engaged in providing coverage, market shares, change in market shares and ease of entry. The insurer shall disclose to the insured that forms and rates under this subsection are exempt from filing requirements. Disclosures made by the insurer shall be maintained by the insurer.


Section 506-A. Rate Filings.--(a) Every insurer making a filing with the commissioner under section 505-A shall file every manual of classifications, rules and rates, every rating plan and every modification of a manual of classifications, rules and rates and a rating plan which it proposes to use in this Commonwealth.

(b) If the commissioner determines that a filing is not accompanied by supporting information and that sufficient information is not available to determine whether the filing meets the requirements of this article, the commissioner may require the insurer to furnish the additional supporting information. Filings may be supported by any or all of the following:

(1) The experience or judgment of the insurer.
(2) The experience of other insurers or rating organizations.
(3) Any other factors which the insurer deems relevant.
(c) An insurer may satisfy its rate filing requirements by becoming a member of or subscriber to a licensed rating organization which makes rate filings and by authorizing the commissioner to accept filings from the rating organization on the insurer's behalf. Nothing contained in this article shall be construed to require any insurer to become a member of or a subscriber to a licensed rating organization.


Section 507-A. Review Procedures.--(a) Filings shall be reviewed as appropriate and necessary to carry out the provisions of this article. The commissioner may publish notice of a filing in the Pennsylvania Bulletin, including the time period established by the department for receipt of public comment on the filing.

(b) Disapproval of a filing shall be based only on specific provisions of applicable law, regulations or statements of policy or on insufficiency of supporting information. Rates filed under section 505-A shall not be disapproved unless the rates are determined to be excessive, inadequate or unfairly discriminatory.

(c) A filing disapproved by the department may be resubmitted within one hundred twenty (120) days after the date of the disapproval. Resubmitted filings shall become effective and may be used thirty (30) days after the receipt of the resubmission by the department unless previously approved or disapproved by the department. The provision of this subsection shall apply to filings made after the effective date of this article.

(d) Disapproval of a resubmitted filing shall be based only on specific provisions of applicable law, regulations or statements of policy or on insufficiency of supporting information. Disapproval may not be based on any grounds not specified in the initial disapproval issued by the department except to the extent that new information is presented in the resubmission.

(e) Any resubmission following a second disapproval shall be considered a new filing and shall be reviewed in accordance with subsection (a).
(f) Nothing in this section shall prevent the commissioner from approving a filing.


Section 508-A. Notice of Disapproval.--Upon the disapproval of any filing under this article, the department shall notify the insurer in writing specifying the reason or reasons for the disapproval.


Section 509-A. Use of Disapproved Forms or Rates.--It shall be unlawful for any insurer to use a form or rate disapproved under this article within this Commonwealth.


Section 510-A. Review of Form or Rate Disapproval.--(a) Within thirty (30) days of the date of mailing a notice of disapproval of a filing under this article, the insurer may make a written application to the commissioner for a hearing.

(b) Upon receipt of an application for a hearing under subsection (a), the commissioner may hold a hearing in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action). All actions which may be performed by the commissioner under this section may be performed by the commissioner's designated representative.


Section 511-A. Disapproval After Use.--(a) Any form or rate filed and used after the expiration of the appropriate review period under this article may be subsequently disapproved. The commissioner shall notify the insurer of the disapproval in writing and shall provide the opportunity for a hearing as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(b) If following a hearing the commissioner finds that a form in use should be disapproved, the commissioner may order its use to be discontinued for any policy issued or reviewed after a date specified in the order.

(c) If following a hearing the commissioner finds that a rate in use should be disapproved, the commissioner may order its use to be discontinued for any policy issued or renewed after a date specified in the order. The commissioner may reinstate the last approved rate on file with the department or specify interim rates.

(d) Pending a hearing, the commissioner may order the suspension of use of any form filed if the commissioner has reasonable cause to believe all of the following:

1. The form is contrary to applicable law or regulations.
2. The insurer will suffer substantial harm if the form is not suspended.
3. The harm the insured will suffer outweighs any hardship the insurer will suffer by the suspension for the use of the form.
4. The suspension order will result in no harm to the public.

(e) Pending a hearing, the commissioner may order suspension of use of a rate filed and reinstate the last previous rate in effect or specify interim rates if none has been previously approved if the commissioner has reasonable cause to believe that:

1. The rate is excessive, inadequate or unfairly discriminatory;
(2) unless a suspension order is issued, insureds will suffer substantial harm;
(3) the harm insureds will suffer outweighs any hardship the insurer will suffer by the suspension of the use of the form; and
(4) the suspension order will result in no harm to the public.


Section 512-A. Rating Organizations.--(a) A corporation, unincorporated association, partnership or individual located within or outside this Commonwealth may make application to the commissioner for a license as a rating organization for the kinds of insurance or subdivisions specified in its application. The applicant shall file the following with the commissioner:
(1) A copy of its constitution, articles of agreement or association, certificate of incorporation and a copy of all bylaws, rules and regulations governing the conduct of its business.
(2) A list of its members and subscribers.
(3) The name and address of a resident of this Commonwealth upon whom notices or orders of the commissioner or process affecting the rating organization may be served.
(4) A statement of its qualifications as a rating organization.

(b) Review.--If the commissioner determines that the information submitted under subsection (a) is acceptable, the commissioner may issue a license specifying the kinds of insurance or subdivisions for which the applicant is authorized to act as a rating organization. A license may be granted or denied in whole or in part by the commissioner within sixty (60) days of the date of its filing.

(c) Licenses issued under this section shall remain in effect for three (3) years unless sooner suspended or revoked by the commissioner. The department shall charge a fee of five thousand dollars ($5,000) for each license. Licenses may be suspended or revoked by the commissioner following notice and hearing if the rating organization ceases to meet the requirements of subsections (a) and (b).

(d) An organization shall notify the commissioner of a change to any of the following:
(1) Its constitution, articles of agreement or association, certificate of incorporation or its bylaws, rules and regulations governing the conduct of its business.
(2) Its list of members and subscribers, which list shall be updated on a quarterly basis.
(3) The name and address of the resident of this Commonwealth designated by it upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

(e) Each rating organization shall permit any nonmember insurer to be a subscriber to its rating services for any kind of insurance or subdivision for which it is authorized to act as a rating organization. Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(f) Prohibition.--No rating organization shall adopt any rule which would prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(g) (1) Cooperation in ratemaking among rating organizations, or among rating organizations and insurers and concert of action among insurers under the same general
management and control, or in other matters within the scope of this article is authorized, provided the resulting filings are subject to all applicable provisions of this article.

(2) If the commissioner finds that an activity or practice described in paragraph (1) is unfair or unreasonable or otherwise inconsistent with the provisions of this article, the commissioner may after notice and hearing issue a written order discontinuing the activity or practice. The order shall specify the reason for a determination that the activity or practice is unfair or unreasonable or otherwise inconsistent with this article.


Section 513-A. Deviation Filings.--(a) (1) Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the rating organization.

(2) A member or subscriber may, notwithstanding paragraph (1), file with the commissioner a uniform percentage decrease or increase to be applied to the premiums produced by the filed rating system for a kind of insurance or class of insurance found by the commissioner to be a proper rating unit for the application of the uniform percentage decrease or increase or for a subdivision of a kind of insurance:

(i) that is comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(ii) for which separate expense provisions are included in the filings of the rating organization.

(b) A deviation filing shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the filing and data shall be sent simultaneously to the rating organization. A deviation filing shall be subject to the provisions of sections 505-A and 507-A.


Section 514-A. Information to Insured.--(a) Every rating organization and every insurer which makes its own rates shall, upon request and payment of reasonable costs, furnish all pertinent information to the affected insured or the insured's authorized representative. The information shall be provided within a reasonable time.

(b) Every rating organization and every insurer which makes its own rates shall provide reasonable procedures for any person aggrieved by the application of its rating system within this Commonwealth to be heard upon written request, in person or by the insured's authorized representative, to review the manner in which the rating system has been applied in connection with the insurance afforded the aggrieved person.


Section 515-A. Examinations.--(a) The commissioner may at least once every five (5) years make or cause to be made an examination of each rating organization licensed in this Commonwealth.

(b) The reasonable costs of an examination under subsection (a) shall be paid by the rating organization upon presentation of a detailed account of the costs. The officers, managers, agents and employees of the rating organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner may furnish two (2) copies of the examination report to the rating organization and shall notify the organization that it may within twenty (20) days request a hearing on the report. Before filing the report for public
inspection, the commissioner may grant a hearing to the rating organization.

(c) When filed for public inspection, the examination report shall be admissible in evidence in any action or proceeding brought by the commissioner against the rating organization examined or its officers and shall be prima facie evidence of the facts stated in it.

(d) The commissioner may withhold the report of any examination from public inspection for such time as the commissioner may deem proper.

(e) In lieu of an examination, the commissioner may accept the report of an examination conducted by the insurance supervisory official of another state under the laws of that state.


Section 516-A. Record Maintenance.--Upon request, the commissioner shall be provided with a copy of any rate or form issued in this Commonwealth. Insurers shall maintain complete and accurate specimens or actual copies of all rates and forms which are issued to Commonwealth residents, including copies of all applications, binders, endorsements and other applicable and supporting documents used with rates and policies. Rate filings and forms may be retained on diskette, microfiche or by any other electronic method. Specimen copies shall also indicate the date the rate filing or form was first issued in this Commonwealth.


Section 517-A. Assigned Risks and Residual Markets.--(a) Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure insurance through ordinary methods, and the insurers may agree among themselves on the use of reasonable rate modifications for the insurance.

(b) Agreements and rate modifications made under subsection (a) shall be subject to the filing, review and prior approval of the commissioner. Filings shall be available for use at the expiration of a sixty-day (60) period if not earlier approved or disapproved by the commissioner. The commissioner may by written order to the insurer within the sixty-day (60) period extend the period for approval or disapproval for an additional thirty (30) days. This section shall apply to filings for the Fair Plan and the Joint Underwriting Association.

(517-A added Dec. 21, 1998, P.L.1108, No.150)

Section 518-A. Violations.--(a) A person or organization shall not wilfully withhold information affecting the rates or premiums chargeable under this article from or knowingly give false or misleading information to the commissioner, a statistical agency designated by the commissioner or an advisory organization. A violation of this section shall be punishable under subsection (b).

(b) Upon satisfactory evidence of a violation of any section of this article by any person or insurer, one (1) or more of the following penalties may be imposed at the commissioner's discretion:

(1) Suspension or revocation of a license.
(2) Refusal for a period not to exceed one (1) year to issue a new license to the offending insurer or other persons.
(3) A fine of not more than five thousand dollars ($5,000) for a violation of this article.
(4) A fine of not more than ten thousand dollars ($10,000) for a wilful violation of this article.
(5) A fine of not more than ten thousand dollars ($10,000) for a violation of subsection (a).

(6) A fine of not more than twenty-five thousand dollars ($25,000) for a wilful violation of section 516-A.

(c) Fines imposed against an individual insurer under this article shall not exceed five hundred thousand dollars ($500,000) in the aggregate during a single calendar year.


Section 519-A. Severability.--The provisions of this article are severable. If any provision of this article or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this article which can be given effect without the invalid provision or application.


ARTICLE VI.

CASUALTY INSURANCE.

(a) GENERAL PROVISIONS RELATING TO STOCK COMPANIES.

Section 601. Financial Requirements of Foreign Companies.--Stock casualty insurance companies of other States and foreign governments, organized to transact any of the classes of insurance mentioned in subdivision (c), section two hundred and two (202) of this act, in order to be licensed to do business in this Commonwealth, must have a paid up and safely invested capital and surplus, if a company of another State, or a deposit in the United States, if a company of a foreign government, of at least the amount required in this act for domestic companies.

(601 amended Dec. 18, 1992, P.L.1519, No.178)


Section 602.1. Eligible Investments.--Every domestic stock casualty insurance company shall invest and keep invested all its funds in accordance with the laws of this Commonwealth relating to the investment of funds of domestic stock fire, stock marine, or stock fire and marine insurance companies.


Section 603. Investment of Surplus; Restrictions.--(603 repealed Dec. 22, 1989, P.L.755, No.106)


Section 604.1. Real Estate Which May Be Acquired, Held and Conveyed.--No domestic stock casualty insurance company shall acquire by purchase, lease or otherwise or receive, hold or convey real estate, or any interest therein, except in accordance with the laws of this Commonwealth relating to real estate that may be acquired by purchase, lease or otherwise or received, held or conveyed by stock fire, stock marine, or stock fire and marine insurance companies.


Section 605. Dividends.--(605 repealed Feb. 17, 1994, P.L.92, No.9)

Section 606. Reduction and Withdrawal of Capital Stock.--Any existing stock casualty insurance company, and any stock casualty insurance company formed under this act, having a paid up capital in excess of the minimum herein required, may reduce the excess, in whole or in part, in the manner hereinbefore provided for the reduction of capital stock by insurance
companies. Any such company which has undertaken two or more kinds of insurance and wishes to discontinue a particular kind may withdraw the entire additional capital paid in on account thereof.

Section 607. Procedure When Capital Impaired.--Any stock casualty insurance company receiving notice from the Insurance Commissioner that its capital is impaired shall immediately call upon its stockholders for such amounts as will restore its capital to the amount fixed by its charter. In case any stockholder neglects or refuses to pay the amount called for, after notice personally given or by advertisement, at such time and in such manner as the commissioner shall approve, the company shall require the return of the original certificate of stock held by such stockholder, and, in lieu thereof, issue new certificates in the proportion that the ascertained value of the assets of the company may, as determined by the commissioner, bear to the original capital; the company paying for any fractional parts of shares. The directors may create new stock, and issue certificates therefor, and dispose of the same, at not less than par, for an amount sufficient to make up the original capital, or the commissioner may, in his discretion, permit the company to reduce its capital and the par value of its shares in proportion to the extent of the impairment, but the capital shall at no time be reduced to an amount less than that required by law for the organization of any such company. In fixing such reduced capital, not more than fifty per centum (50%) of the original capital shall be deducted from the assets on hand, to be retained as surplus funds; nor shall any part of the assets be distributed to stockholders.

Compiler's Note: Section 401(b) of Act 198 of 1990 provided that section 607 is repealed insofar as it prohibits the use of shares without par value.


Section 609. Companies to Which Act Applies.--That all stock casualty insurance companies, heretofore or hereafter incorporated or formed by authority of any general or special law, shall be subject to the provisions and requirements of this act.

(609 amended June 4, 1937, P.L.1642, No.341)

Section 610. Foreign Companies, Associations, and Exchanges to Do Business through Resident Agents.--(610 repealed Dec. 21, 1998, P.L.1108, No.150)

(b) HEALTH AND ACCIDENT INSURANCE.

Section 616. Copies of Policies to Be Filed With and Approved by the Insurance Commissioner.--(616 repealed Dec. 18, 1996, P.L.1066, No.159)

Section 617. Conditions Subject to Which Policies Are to Be Issued.--(A) No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless:

(1) the entire money and other considerations therefor are expressed therein; and
(2) the time at which the insurance takes effect and terminates is expressed therein; and
(3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult head of a family who shall be deemed the policyholder, any two or more eligible members of that
family, including husband, wife, dependent children or any
children under a specified age which, except as provided under
section 617.1, shall not exceed nineteen years and any other
person dependent upon the policyholder; and ((3) amended June
10, 2009, P.L.42, No.4)

(4) the style, arrangement and over-all appearance of the
policy give no undue prominence to any portion of the text, and
unless every printed portion of the text of the policy and of
any endorsements or attached papers is plainly printed in
light-faced type of a style in general use, the size of which
shall be uniform and not less than ten-point with a lower-case
unspaced alphabet length not less than one hundred and
twenty-point (the "text" shall include all printed matter except
the name and address of the insurer, name or title of the
policy, the brief description, if any, and captions and
subcaptions); and

(5) the exceptions and reductions of indemnity are set forth
in the policy and, except those which are set forth in section
six hundred eighteen of this act, are printed, at the insurer's
option, either included with the benefit provision to which
they apply, or under an appropriate caption such as
"exceptions," or "exceptions and reductions": Provided, That
if an exception or reduction specifically applies only to a
particular benefit of the policy, a statement of such exception
or reduction shall be included with the benefit provision to
which it applies; and

(6) each such form, including riders and endorsements, shall
be identified by a form number in the lower left-hand corner
of the first page thereof; and

(7) it contains no provision purporting to make any portion
of the charter, rules, constitution, or by-laws of the insurer
a part of the policy unless such portion is set forth in full
in the policy, except in the case of the incorporation of, or
reference to, a statement of rates or classification of risks,
or short-rate table filed with the commissioner; and

(8) if such policy is entitled or referred to as
"non-cancellable," such "non-cancellable" policy is
automatically renewable until age sixty upon payment of the
required premiums by the insured; and ((8) amended July 31,
1968, P.L.1031, No.311)

(9) A policy delivered or issued for delivery after January
1, 1968, under which coverage of a dependent of a policyholder
terminates at a specified age shall, with respect to an
unmarried child covered by the policy prior to the attainment
of the age of nineteen who is incapable of self-sustaining
employment by reason of mental retardation or physical handicap
and who became so incapable prior to attainment of age nineteen
and who is chiefly dependent upon such policyholder for support
and maintenance, not so terminate while the policy remains in
force and the dependent remains in such condition, if the
policyholder has within thirty-one days of such dependent's
attainment of the limiting age submitted proof of such
dependent's incapacity as described herein. The foregoing
provisions of this paragraph shall not require an insurer to
insure a dependent who is a mentally retarded or physically
handicapped child where the policy is underwritten on evidence
of insurability based on health factors set forth in the
application or where such dependent does not satisfy the
conditions of the policy as to any requirement for evidence of
insurability or other provisions of the policy, satisfaction
of which is required for coverage thereunder to take effect.
In any such case the terms of the policy shall apply with regard
to the coverage or exclusion from coverage of such dependent. 
(9) added Jan. 18, 1968, 1967 P.L.969, No.433)

(10) Except for a single premium nonrenewable policy, it shall have prominently printed thereon a notice stating in substance that the policyholder shall be permitted to return the policy within ten days of its delivery and to have the premium paid refunded if after examination of the policy, the policyholder is not satisfied with it for any reason. If a policyholder pursuant to such notice, returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. ((10) added July 31, 1968, P.L.1031, No.311)

(B) If any policy is issued by an insurer domiciled in this Commonwealth for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (A) of this section and in section six hundred eighteen.

(617 added May 25, 1951, P.L.417, No.99)

Compiler's Note: Section 3 of Act 4 of 2009, which amended section 617, provided that Act 4 shall apply to new contracts and contract renewals occurring 90 days after the effective date of Act 4.

Section 617.1. Health Insurance Coverage for Certain Children of Insured Parents.- (A) An insurer that issues, delivers, executes or renews group health care insurance in this Commonwealth under which coverage of a child would otherwise terminate at a specified age shall, at the option of the policyholder, provide coverage to a child of an insured employe beyond that specified age, up through and including the age of 29, at the insured employe's expense, and provided that the child meet all of the following requirements:

(1) Is not married.
(2) Has no dependents.
(3) Is a resident of this Commonwealth or is enrolled as a full-time student at an institution of higher education.
(4) Is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program, including benefits under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

(B) Insurers may determine increases in premiums related to continuation of coverage for the adult dependent past the limiting age of nineteen.

(C) This section shall not include the following types of insurance or any combination thereof:
(1) Hospital indemnity.
(2) Accident.
(3) Specified disease.
(4) Disability income.
(5) Dental.
(6) Vision.
(7) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.
(8) Medicare supplement.
(9) Long-term care.
(10) Other limited benefit plans.
(11) Individual health insurance policies.
(D) For the purpose of this section:
"Health care insurance" means a group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to any one of the following:
(1) This act.
(2) The act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act."
(3) The act of May 18, 1976 (P.L. 123, No. 54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."
(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
(5) Article XXIV.
(617.1 added June 10, 2009, P.L. 42, No. 4)

Compiler's Note: Section 3 of Act 4 of 2009, which added section 617.1, provided that Act 4 shall apply to new contracts and contract renewals occurring 90 days after the effective date of Act 4.

Section 618. Policy Provisions.--(A) Required Provisions. Except as provided in paragraph (C) of this section, each such policy delivered or issued for delivery to any person in this Commonwealth shall contain the provisions specified in this subsection in the words in which they appear in this section: Provided, however, That the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or sub-captions as the commissioner may approve.
(1) A provision as follows:
Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.
(2) A provision as follows:
Time Limit on Certain Defenses: (a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three year period.
(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three year period, nor to limit the application of section six hundred eighteen (B), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)
(In a policy where the premiums are payable weekly, the words "if such application is made a part of the policy" may be inserted in the foregoing policy provision between the word "policy" and the word "shall" immediately following.)
(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable". After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(In policies whereon the premiums are payable weekly, the words "or from the date of any reinstatement thereof" may be inserted in the foregoing policy provision between the word "policy" and the word "shall" immediately following.)

(3) A provision as follows:

Grace Period: A grace period of ............ (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.")

(A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,").

(4) A provision as follows:

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with
a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. (The last sentence of the above provision may be omitted (a) from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from the date of its issue and, (b) from any policy on which the premiums are payable weekly.)

(5) A provision as follows:

Notice of Claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ........... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy whereon the premiums are payable weekly, the first sentence of the foregoing policy provision may read "written notice of claim must be given to the insurer within ten days of the commencement of any non-hospital confining sickness covered by the policy and within twenty days after the occurrence or commencement of any other loss covered by the policy, or as soon thereafter as is reasonably possible".)

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may, at its option, insert the following between the first and second sentences of the above provision: Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) A provision as follows:

Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The claim form to be used under this clause is the Health Care Financing Administration Form-1500. The provision for Health Care Financing Administration Form-1500 shall not apply to medical payments made by the Federal Government. ((6) amended Apr. 3, 1992, P.L.44, No.13)

(7) A provision as follows:

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for
which this policy provides any periodic payment contingent upon
continuing loss within ninety days after the termination of the
period for which the insurer is liable and in case of claim for
any other loss within ninety days after the date of such loss.
Failure to furnish such proof within the time required shall
not invalidate nor reduce any claim if it was not reasonably
possible to give proof within such time, provided such proof
is furnished as soon as reasonably possible and in no event,
except in the absence of legal capacity, later than one year
from the time proof is otherwise required.

(8) A provision as follows:
Time of Payment of Claims: Indemnities payable under this
policy for any loss other than loss for which this policy
provides any periodic payment will be paid immediately upon
receipt of due written proof of such loss. Subject to due
written proof of loss, all accrued indemnities for loss for
which this policy provides periodic payment will be paid
........................ (insert period for payment which must not be
less frequently than monthly) and any balance remaining unpaid
upon the termination of liability will be paid immediately upon
receipt of due written proof.

(9) A provision as follows:
Payment of Claims: Indemnity for loss of life will be payable
in accordance with the beneficiary designation and the
provisions respecting such payment which may be prescribed
herein and effective at the time of payment. If no such
designation or provision is then effective, such indemnity shall
be payable to the estate of the insured. Any other accrued
indemnities unpaid at the insured's death may, at the option
of the insurer, be paid either to such beneficiary or to such
estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included
with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the
estate of the insured, or to an insured or beneficiary who is
a minor or otherwise not competent to give a valid release, the
insurer may pay such indemnity, up to an amount not exceeding
$................ (insert an amount which shall not exceed $1000),
to any relative by blood or connection by marriage of the
insured or beneficiary who is deemed by the insurer to be
equitably entitled thereto. Any payment made by the insurer in
good faith pursuant to this provision shall fully discharge the
insurer to the extent of such payment.

Subject to any written direction of the insured in the
application or otherwise, all or a portion of any indemnities
provided by this policy on account of hospital, nursing,
medical, or surgical services may, at the insurer's option and,
unless the insured requests otherwise in writing, not later
than the time of filing proofs of such loss, be paid directly
to the hospital or person rendering such services; but it is
not required that the service be rendered by a particular
hospital or person.)

(10) A provision as follows:
Physical Examinations and Autopsy: The insurer at its own
expense shall have the right and opportunity to examine the
person of the insured when and as often as it may reasonably
require during the pendency of a claim hereunder and to make
an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:
Legal Actions: No action at law or in equity shall be brought
to recover on this policy prior to the expiration of sixty days
after written proof of loss has been furnished in accordance
with the requirements of this policy. No such action shall be
brought after the expiration of three years after the time
written proof of loss is required to be furnished.

(12) A provision as follows:
    Change of Beneficiary: Unless the insured makes an
irrevocable designation of beneficiary, the right to change of
beneficiary is reserved to the insured and the consent of the
beneficiary or beneficiaries shall not be requisite to surrender
or assignment of this policy or to any change of beneficiary
or beneficiaries, or to any other changes in this policy.
(The first clause of this provision, relating to the
irrevocable designation of beneficiary, may be omitted at the
insurer's option.)

(B) Other Provisions. Except as provided in paragraph (C)
of this section, no such policy delivered or issued for delivery
to any person in this Commonwealth shall contain provisions
respecting the matters set forth below unless such provisions
are in the words in which the same appear in this section:
Provided, however, That the insurer may, at its option, use in
lieu of any such provision, a corresponding provision of
different wording approved by the commissioner, which is not
less favorable in any respect to the insured or the beneficiary.
Any such provision contained in the policy shall be preceded
individually by the appropriate caption appearing in this
subsection or, at the option of the insurer, by such appropriate
individual or group captions or subcaptions as the commissioner
may approve.

(1) A provision as follows:
    Change of Occupation: If the insured be injured or contract
sickness after having changed his occupation to one classified
by the insurer as more hazardous than that stated in this policy
or while doing for compensation anything pertaining to an
occupation so classified, the insurer will pay only such portion
of the indemnities provided in this policy as the premium paid
would have purchased at the rates and within the limits fixed
by the insurer for such more hazardous occupation. If the
insured changes his occupation to one classified by the insurer
as less hazardous than that stated in this policy, the insurer,
upon receipt of proof of such change of occupation, will reduce
the premium rate accordingly, and will return the excess
pro-rata unearned premium from the date of change of occupation
or from the policy anniversary date immediately preceding
receipt of such proof, whichever is the more recent. In applying
this provision, the classification of occupational risk and the
premium rates shall be such as have been last filed by the
insurer prior to the occurrence of the loss for which the
insurer is liable or prior to date of proof of change in
occupation with the state official having supervision of
insurance in the state where the insured resided at the time
this policy was issued; but if such filing was not required,
then the classification of occupational risk and the premium
rates shall be those last made effective by the insurer in such
state prior to the occurrence of the loss or prior to the date
of proof of change in occupation.

(2) A provision as follows:
    Misstatement of Age: If the age of the insured has been
misstated, all amounts payable under this policy shall be such
as the premium paid would have purchased at the correct age.

(3) A provision as follows:
    Other Insurance in This Insurer: If an accident or sickness
or accident and sickness policy or policies previously issued
by the insurer to the insured be in force concurrently herewith,
making the aggregate indemnity for ........ (insert type of coverage or coverages) in excess of $....... (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate or, in lieu thereof, insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows:

Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the next following policy provision, there shall be added to the caption of the foregoing provision the phrase "---------Expense Incurred Benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition, such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision, no third party liability coverage shall be included as "other valid coverage".)

(5) A provision as follows:

Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the
indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "------------ other benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition, such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employe benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision, no third party liability coverage shall be included as "other valid coverage".)

(6) A provision as follows:

Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage, the inclusion of which may be approved by the
commissioner, or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employe benefit organizations.)

(7) A provision as follows:
Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows:
Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(9) A provision as follows:
Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

(10) A provision as follows:
Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony, or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) A provision as follows:
Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician.

(C) Inapplicable or Inconsistent Provisions. If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(D) Order of Certain Policy Provisions. The provision which are the subject of subsections (A) and (B) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous,
abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(E) Third Party Ownership. The word "insured", as used in this act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(F) Filing Procedure. The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this act as are necessary, proper or advisable to the administration of this act. This provision shall not abridge any other authority granted the commissioner by law.

(618 added May 25, 1951, P.L.417, No.99)

Compiler's Note: Section 15(a) of Act 106 of 1990 provided that section 618(B)(11) is repealed insofar as it is inconsistent with Act 106.

Section 619. Age Limit.--If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(619 added May 25, 1951, P.L.417, No.99)

Section 619.1. Reduction For Cost-of-living Increase Prohibited.--No claim for benefits for loss of time from the insured person's occupation, under a group or individual accident and health insurance policy issued or renewed in this State, shall be reduced by reason of any cost-of-living increase, designated as such under the Federal Social Security Act, if such cost-of-living increase occurs while the policy's benefits are payable for that claim.

(619.1 added July 16, 1975, P.L.72, No.42)

Section 620. Requirements of Other Jurisdictions.--(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this Commonwealth, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this act and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(620 added May 25, 1951, P.L.417, No.99)

Section 621. Conforming to Statute.--(A) Other Policy Provisions. No policy provision which is not subject to section six hundred eighteen of this act shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this act.
(B) Policy Conflicting with This Act. A policy delivered or issued for delivery to any person in this Commonwealth in violation of this act shall be held valid but shall be construed as provided in this act. When any provision in a policy subject to this act is in conflict with any provision of this act, the rights, duties and obligations of the insurer, the insured and the beneficiary, shall be governed by the provisions of this act.

(621 added May 25, 1951, P.L.417, No.99)
Section 621.1. Group Accident and Health Insurance.--(621.1 repealed Dec. 9, 1955, P.L.807, No.233)
Section 621.2. Group Accident and Sickness Insurance.--(a)
Group accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering groups of persons defined in this section with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups or persons and issued upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder insuring at least two employees of such employer for the benefit of persons other than the employer. The term "employees," as used herein, shall be deemed to include the officers, managers and employees of the employer, the individual proprietor or partner, if the employer is an individual proprietor or partnership, the officers, managers and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise. The term "employees," as used herein, may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. ((1) amended July 9, 2010, P.L.362, No.51)

(2) Under a policy issued to an association, including a labor union, which shall have a constitution and by-laws and which has been organized by other than an insurer and is maintained in good faith for purposes other than that of obtaining insurance insuring at least twenty-five members, employees or employees of members of the association for the benefit of persons other than the association or its officers or trustees, which has been in active existence for at least two years, operates from offices other than the insurer's and is controlled by principals other than the insurer's. The term "employees," as used herein, may include retired employees.

(3) Under a policy issued to the trustees of a fund established by an insurer for two or more employers or by two or more employers or by an insurer for one or more labor unions or by one or more labor unions or by an insurer for one or more employers and one or more labor unions or by one or more employers and one or more labor unions or by an insurer for one or more associations meeting the qualifications as defined in clause (2) or by one or more associations meeting the qualifications as defined in clause (2), which trustees shall be deemed the policyholder to insure employees of the employers or members of the unions or members, employes thereof and employees of the associations for the benefit of persons other than the employers or the unions or the associations. The term "employees," as used herein, may include the officers, managers and employees of the employer and the individual proprietor or
partners, if the employer is an individual proprietor or partnership. The term "employes," as used herein, may include retired employes. The policy may provide that the term "employes" shall include the trustees or their employes, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this Commonwealth to insure any class or classes of individuals that could be insured under such group life policy.

(5) Under a policy issued to cover any other substantially similar group, which in the discretion of the Insurance Commissioner may be subject to the issuance of a group accident and sickness policy or contract.

(5.1) Under a policy issued to a group, other than one described in clauses (1) through (5) and under which the Insurance Commissioner finds that the issuance is not contrary to the best interest of the public, the issuance would result in economies of acquisition or administration, and the benefits are reasonable in relation to the premiums charged.

(6) A policy delivered or issued for delivery on or after January 1, 1968 under which coverage of a dependent of an employe or other member of the insured group terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of the age of nineteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age nineteen and who is chiefly dependent upon such employe or member for support and maintenance, not so terminate while the insurance of the employe or member remains in force and the dependent remains in such condition, if the insured employe or member has within thirty-one days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not require an insurer to insure a dependent who is a mentally retarded or physically handicapped child of an employe or other member of the insured group where such dependent does not satisfy the conditions of the group policy as to any requirements for evidence of insurability or other provisions as may be stated in the group policy required for coverage thereunder to take effect. In any such case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent.

((a) amended Feb. 17, 1994, P.L.92, No.9)

(b) Each group accident and sickness policy shall contain in substance the following provisions:

(1) A provision that in the absence of fraud, all statements made by any applicant or applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits, unless contained in a written instrument signed by the policyholder or the insured person a copy of which has been furnished to such policyholder or to such person or his beneficiary.

(2) A provision that the insurer will furnish to the policyholder, for delivery to each employe or member of the insured group, an individual certificate setting forth, in summary form, a statement of the essential features of the insurance coverage of such employe or member and to whom
benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(c) Any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy, on account of hospital, nursing, medical or surgical services, may at the insurer's option be paid directly to the hospital or person rendering such services. Except as provided in section 630, the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. ((c) amended June 11, 1986, P.L.226, No.64)

(d) A group policy delivered or issued for delivery in this State which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, but not a policy which provides indemnity benefits or benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a policy of health insurance (hereafter referred to as the converted policy). An employee or member shall not be entitled to have a converted policy issued to him if termination of his insurance under the group policy occurred because he failed to pay any required contribution, or any discontinued group coverage was replaced by similar group coverage within thirty-one days. Issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than thirty-one days after such termination.

(2) The converted policy shall be issued without evidence of insurability.

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs and to his age attained on the effective date of the individual policy.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:
(i) (I) such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or

(II) such person is eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(III) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or Federal law; and

(ii) the benefits provided under the sources referred to in subclause (i)(I) for such person or benefits provided or available under the sources referred to in subclauses (i)(II) and (III) for such person together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered thereunder as to whether:

(i) he is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(ii) he is covered for similar benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis; or

(iii) similar benefits are provided for or are available to such person, pursuant to or in accordance with the requirements of any state or Federal law. The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured thereunder for the following reasons only:

(I) Either the benefits provided under the sources referred to in clause (7)(i) and (ii) for such person or benefits provided or available under the sources referred to in clause (7)(iii) for such person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer standards on file with the commissioner, or the converted policyholder fails to provide the requested information.

(II) Fraud or material misrepresentation in applying for any benefits under the converted policy.

(III) Eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or Federal law providing for benefits similar to those provided by the converted policy.

(IV) Other reasons approved by the commissioner.

(8) An insurer shall not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(9) The converted policy shall not exclude a pre-existing condition not excluded by the group policy. However, the
converted policy may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy shall not exceed those that would have been payable had the individual insurance under the group policy remained in force and effect.

(10) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employe or member for basic hospital or surgical expense insurance, the employe or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

(i) Plan A:

(I) hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in metropolitan areas of this State, for a maximum duration of seventy days;

(II) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars ($800);

or

(ii) Plan B:

(I) hospital room and board daily expense benefits in a maximum dollar amount equal to seventy-five per centum (75%) of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days;

(II) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of six hundred dollars ($600);

or

(iii) Plan C:

(I) hospital room and board daily expense benefits in a maximum dollar amount equal to fifty per centum (50%) of the maximum dollar amount determined for Plan A, for a maximum duration of seventy days;

(II) miscellaneous hospital benefits of a maximum amount of ten times the hospital room and board daily expense benefits; and

(III) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of four hundred dollars ($400).

The maximum dollar amounts in Plan A shall be determined by the commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in Plans A, B and C shall be rounded to the nearest multiple of ten dollars ($10).
Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(i) A maximum benefit at least equal to either, at the option of the insurer in paragraph (I) or (II):

(I) The smaller of the following amounts: the maximum benefit provided under the group policy or a maximum payment of two hundred fifty thousand dollars ($250,000) per covered person for all covered medical expenses incurred during the covered person's lifetime.

(II) The smaller of the following amounts: the maximum benefit provided under the group policy or a maximum payment of two hundred fifty thousand dollars ($250,000) for each unrelated injury or sickness.

(ii) Payment of benefits at the rate of eighty per centum (80%) of covered medical expenses which are in excess of the deductible, until twenty per centum (20%) of such expenses in a benefit period reaches one thousand dollars ($1,000), after which benefits will be paid at the rate of one hundred per centum (100%) during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty per centum (50%).

(iii) A deductible for each benefit period which, at the option of the insurer, shall be:

(I) the sum of the benefits deductible and one hundred dollars ($100); or

(II) a cash deductible, not to exceed one thousand dollars ($1,000); or

(III) the greater of the benefits deductible or five hundred dollars ($500); or

(IV) the corresponding deductible in the group policy.

The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or Federal law and, if pursuant to clause (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by subclause (i)(II), the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars ($100) or less, and not less than six months if the deductible exceeds one hundred dollars ($100).

(iv) The benefit period shall be each calendar year when the maximum benefit is determined by subclause (i)(I) or twenty-four months when the maximum benefit is determined by subclause (i)(II).

(v) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer.
under group or individual health insurance policies and must provide at least a one thousand two hundred dollars ($1,200) maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employe or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in clauses (10) and (11). At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in clauses (10) and (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of clause (11): Provided, however, That an insurer electing to provide such a policy shall make available a low deductible option, not to exceed one hundred dollars ($100), a high deductible option between five hundred dollars ($500), and one thousand dollars ($1,000), and a third deductible option midway between the high and low deductible options.

(13) The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employe following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had his insurance terminated at retirement by reason of termination of employment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon his eligibility for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or Federal law providing for benefits similar to those provided by the converted policy.

(16) The conversion privilege shall also be available:
   (i) to the surviving spouse, if any, at the death of the employe or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents coverage following the employe's or member's death, at the end of such continuation;
   (ii) to the spouse of the employe or member upon termination of coverage of the spouse, while the employe or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or
   (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in clause (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in clause (10).
(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

Each certificate holder in the insured group shall be given written notice of such conversion privilege and its duration within fifteen days before or after the date of termination of group coverage, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of group coverage, the time allowed for the exercise of such privilege of conversion shall be extended for fifteen days after the giving of such notice. If such notice be not given within ninety days after the date of termination of group coverage, the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days. Written notice by the contract holder given to the certificate holder or mailed to the certificate holder at his last known address, or written notice by the insurer mailed to the certificate holder at the last address furnished to the insurer by the contract holder, shall be deemed full compliance with the provisions of this clause for the giving of notice. A group contract issued by an insurer may contain a provision to the effect that notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

(20) Where the contract holder is the employer of the certificate holder, the insurer shall also give written notice of termination of the group contract to any organization or organizations representing such certificate holder for the purpose of collective bargaining, and the employer shall provide to the insurer a written list of such organizations within ten days after the date the policy is issued and thereafter within ten days of the beginning or termination of representation by any such organization of any certificate holder or holders, which list shall identify the collective bargaining unit and the group insurance contract to which the request relates. There shall be no liability on the part of, and no cause of action of any nature shall arise, against any labor organization representing the employees of a contract holder for the purposes of collective bargaining due to any action it takes or fails to take as to the written notice required to be given by the insurer under this clause unless shown to have been done in bad faith with malice in fact by any such organization.

Compliance or non-compliance with the provisions of this clause shall in no way affect the rights, duties or obligations of the contract holder, insurer or certificate holder as otherwise set forth in this act.

(21) A converted policy which is delivered outside this State may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

((d) added July 9, 1976, P.L.952, No.185)

(e) No insurer shall issue in this Commonwealth group accident and health insurance coverage provided under a group policy issued in another state or deliver or issue for delivery in this Commonwealth a certificate of group accident and health insurance evidencing coverage under a group policy issued in another state unless:

(1) such coverage is in compliance with the requirements of this act and any other applicable act; or
(2) for coverage under a group policy or a certificate evidencing coverage under a group policy issued to an out-of-State trustee of a fund, such coverage is issued in another state wherein the insurance supervisory official or agency of that state has determined that the issuance of the group policy or certificate is not contrary to the best interests of the general public, the issuance of the group policy or certificate would result in economies of acquisition or administration, the benefits are reasonable in relation to the premium charged and such coverage is in compliance with any mandated benefit act specifically providing for coverage on residents of this Commonwealth regardless of whether the group policy is used within or outside this Commonwealth. If coverage or a certificate is issued in this Commonwealth pursuant to this clause, an insurer shall file with the Insurance Department a copy of the group policy and certificate, a copy of the statute from the state in which the group policy or certificate is issued authorizing the issuance of the group policy or certificate, evidence of approval in the state where the policy or certificate is issued and copies of all supportive material used by the company to secure approval of the group policy or certificate in that state, including all the documentation required in this clause. The Insurance Commissioner, at any time subsequent to receipt of such information, after finding that the standards of this clause have not been met, may order the insurer to stop marketing such coverage in this Commonwealth.

(i) This clause shall apply to any group policy or certificate evidencing coverage under a group policy issued to any organization or to any trust or trustee of a trust established or participated in by one or more organizations to insure certain persons, provided, however, that the organization must be:

(A) a bank, retailer or other issuer of a credit card, charge card or payment card that is issued to buy goods or services, and the policy must insure holders of that card; or

(B) a bank, savings and loan association, credit union, mutual fund, money market fund, stock broker or other similar financial institution regulated by state or Federal law, and the policy must insure the depositors, account holders or members of that institution.

(ii) This clause shall not apply to any group policy or certificate providing credit accident and health insurance as defined in the act of September 2, 1961 (P.L.1232, No.540), known as the "Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance."

((e) added Feb. 17, 1994, P.L.92, No.9)

(f) The provisions of this act shall not apply if a group policy is issued to:

(1) An out-of-State single employer.

(2) A trustee of a fund established by any person acting directly as an employer having its principal office located in a state other than this Commonwealth.

(3) An association or a trust or trustee of a trust established or participated in by one or more associations to insure association members or spouses or dependents of members, provided, however, that the association must be organized or domiciled in a state other than this Commonwealth, have a constitution and bylaws, be organized by other than an insurer, be maintained in good faith for purposes other than those of obtaining insurance, have been in active existence for at least
two years, operate from offices other than the insurer's and be controlled by principals other than the insurer's.

(4) A union-negotiated out-of-State trust.

(5) Other groups as may be determined by the Insurance Commissioner, subject to subsection (e).

((f) added Feb. 17, 1994, P.L.92, No.9)

(g) (1) For group accident and health insurance coverage provided in this Commonwealth under a policy issued in another state and except as provided in clause (2) of subsection (e) and subsection (f), all group policies, certificates, amendments, endorsements and enrollment forms shall be filed with the commissioner for approval. The insurer shall also file with the commissioner evidence of approval in the state where the group policy is issued.

(2) Forms so filed for approval shall be subject to the provisions of section 354.

((g) added Feb. 17, 1994, P.L.92, No.9)

(h) (1) In the case of a policy issued to a group described in clause (2) or (5.1) of subsection (a) on a group basis, if compensation of any kind will or may be paid to a policyholder or sponsoring or endorsing entity, the insurer shall cause to be distributed to prospective insureds in a written notice that compensation will or may be paid.

(2) Such notice shall be distributed:

(i) whether compensation is direct or indirect; and

(ii) whether such compensation is paid to or retained by the policyholder or sponsoring or endorsing entity or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity or any entity affiliated therewith by way of ownership, contract or employment.

(3) The notice required by this section shall be placed on or accompany any application or enrollment form provided to prospective insureds.

(4) As used in this subsection, a "sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with such organization or that it encourages participation in the program.

((h) added Feb. 17, 1994, P.L.92, No.9)

(i) The provisions of this amendatory act shall not invalidate or otherwise affect either group policies legally issued prior to the effective date of this section or certificates in effect prior to the effective date of this section. All such group policies or certificates may remain in full force and effect until three years after the effective date of this section, notwithstanding the fact they do not comply with the provisions of this act. ((i) added Feb. 17, 1994, P.L.92, No.9)

(j) Any group policy issued on or after the effective date of this subsection shall comply with the provisions of this act. ((j) added Feb. 17, 1994, P.L.92, No.9)

(k) Certificates issued on or after the effective date of this subsection under a group policy legally issued prior to the effective date of this subsection shall comply with the provisions of this act no later than three years after the effective date of this subsection if issued to an employer or trustees of a fund established by an employer or trustees of a fund established by two or more employers none of whom has joined after the effective date of this subsection, labor union, police fraternity, firemen's fraternity, teacher's association
or federation and a unit of the National Guard or Naval Militia. Any other certificates issued on or after the effective date of this subsection under a group policy issued prior to the effective date of this subsection shall comply with the provisions of this act. ((k) added Feb. 17, 1994, P.L.92, No.9)

(l) Any certificate issued under a group policy issued on or after the effective date of this subsection shall comply with the provisions of this act. ((l) added Feb. 17, 1994, P.L.92, No.9)

(m) As used in this section, the term "out-of-State single employer" means any person acting directly as an employer and has its principal office located in a state other than this Commonwealth. An "out-of-State trustee" of a fund means a trustee of a fund established by an insurer for two or more employers or established by two or more persons acting directly as employers and the trustee has its principal office located in a state other than this Commonwealth. "Out-of-State coverage" means insurance coverage issued in this Commonwealth and provided under a group policy issued in a state other than this Commonwealth. A "union-negotiated out-of-State trust" means a trust established under a collective bargaining agreement and which is located in a state other than this Commonwealth. ((m) added Feb. 17, 1994, P.L.92, No.9)

Compiler's Note: Section 14(b) of Act 159 of 1996 provided that section 621.2(a)(1) is repealed insofar as it defines the number of employees in a group insurance policy.

Section 621.3. Blanket Accident and Sickness Insurance.--(a) Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering groups of persons in the following manner:

(1) Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder covering all persons or all persons of a class who may become passengers on such common carrier or such means of transportation.

(2) Under a policy or contract issued to an employer who shall be deemed the policyholder, covering all employes, dependents or guests defined by reference to specified hazards, incident to the activities or operations of the employer or any class of employes, dependents or guests similarly defined.

(3) Under a policy or contract issued to a school or other institution of learning, camp or sponsor thereof, or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers and which may cover supervisors and employes.

(4) Under a policy or contract issued in the name of any religious, charitable, recreational, educational or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization.

(5) Under a policy or contract issued to a sports team or sponsors thereof, which shall be deemed the policyholder covering members, officials and supervisors.

(6) Under a policy or contract issued to cover any other risk or class of risks, which in the discretion of the Insurance Commissioner may be properly eligible for blanket accident and sickness insurance. The discretion of the Commissioner may be exercised on an individual risk basis or class of risks, or both.
(b) Every blanket accident and sickness insurance policy shall contain provisions which, in the opinion of the Insurance Commissioner, are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice, and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within thirty days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy, other than benefits for loss of time, will be payable immediately upon receipt of due written proof of such loss and that subject to due proof of loss all accrued benefits, payable under the policy for loss of time, will be paid not later than at the expiration of each period of thirty days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendence of claim under the policy and also the right and opportunity to make an autopsy, in case of death, where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
(c) An individual application shall not be required from a person covered under a blanket accident or sickness policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(d) Except as otherwise provided in this section, all benefits under any blanket accident and health policy shall be payable to the person insured or to his designated beneficiary or beneficiaries or to his estate. If the person insured be a minor or mental incompetent, such benefits may be made payable to his parent, guardian or other person actually supporting him, or if the entire cost of the insurance has been borne by the employer, such benefits may be made payable to the employer. The policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(621.3 added Dec. 9, 1955, P.L.807, No.233)

Section 621.4. Franchise Accident and Sickness Insurance.--Accident and sickness insurance on a franchise plan is hereby declared to be that form of accident and sickness insurance issued to:

(1) Five or more employees of any corporation, partnership or individual employer or any governmental corporation, agency or department thereof.

(2) Ten or more members, employees or employes of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years, where such association or union has a constitution or by-laws and is formed in good faith for purposes other than that of obtaining insurance, where such persons with or without their dependents are issued the same form of an individual policy, varying only as to amounts and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions or by the association for its members or by some designated person acting on behalf of such employer or association. The term "employees" as used herein, shall be deemed to include the officers, managers and employes of the employer and the individual proprietor or partners, if the employer is an individual proprietor or partnership.

(621.4 added Dec. 9, 1955, P.L.807, No.233)

Section 621.5. Companies Authorized to Write Group, Blanket and Franchise Policies.--Any insurance company authorized to write accident and sickness insurance in this Commonwealth shall have the power to issue group, accident and sickness insurance, blanket accident and sickness insurance and franchise accident and sickness insurance as defined in this act.

(621.5 added Dec. 9, 1955, P.L.807, No.233, and last sentence repealed Dec. 18, 1996, P.L.1066, No.159)

Section 622. False Statements in Applications.--The falsity of any statement in the application for any policy covered by subdivision (b) of this article shall not bar the right to recovery thereunder, unless such false statement was made with actual intent to deceive, or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.
Section 623. Application.--No alteration of any written application for such a policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(623 amended Nov. 4, 1997, P.L.492, No.51)

Section 624. Rights of Insurer Not Waived.--The acknowledgment by any insurer of the receipt of notice given under any policy covered by subdivision (b) of this article, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Section 625. Policies Unlawfully Issued.--A policy issued in violation of subdivision (b) of this article shall be held valid, but shall be construed as provided herein, and when any provision in such a policy is in conflict with any said provision, such provision so conflicting shall be invalid and the policy shall be deemed to contain all of the required provisions.

(625 added May 25, 1951, P.L.417, No.99)

Section 626. Discrimination Prohibited.--Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited, except as provided in section 630.

(626 amended June 11, 1986, P.L.226, No.64)

Section 627. Approval of Policies.--(627 repealed May 25, 1951, P.L.417, No.99)

Section 628. Penalties.--Any company or other insurer, or any officer or agent thereof, which or who issues or delivers to any person in this Commonwealth any policy, or alters any written application for insurance, in violation of the provisions of subdivision (b) of this article, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than three hundred dollars for each offense. The Insurance Commissioner may, in his discretion, take, against the offending party, any one or more of the following courses of action: (1) Revoke the license of any company, corporation, association, or other insurer of another State or country, or of the agent thereof, which or who violates any of said provisions; (2) impose a penalty of not more than one thousand dollars for each act of violation of any of the provisions of said subdivision (b) of this article. Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the person, company, association, or exchange, accused of violating the law, stating specifically the nature of such alleged violation, and fixing a time and place, at least ten (10) days thereafter, when a hearing of the matter shall be held. After such hearing or upon failure of the accused to appear at such hearing, the Insurance Commissioner shall impose such of the above penalties as he deems advisable.


Section 629. Limitations.--

(a) Nothing in subdivision (b) of this article shall apply to or affect any policy of workmen's compensation insurance. The provisions of sections six hundred sixteen, six hundred
seventeen, six hundred eighteen, six hundred nineteen, six hundred twenty-one and six hundred twenty-three of this act shall not apply to those forms of health and accident policies enumerated in section six hundred twenty-one and one-tenth of this act, except as provided in said section. ((a) amended May 25, 1951, P.L.417, No.99)

(b) Nothing in subdivision (b) of this article shall apply to nor in any way affect life insurance, endowment or annuity contracts, or contracts supplemental thereto, which contain only such provisions relating to accident and health insurance as (a) provide additional benefits in case of death by accidental means, and as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. The Insurance Commissioner shall have power to make reasonable rules and regulations concerning such provisions. ((b) amended July 19, 1951, P.L.1100, No.245)

(c) ((c) repealed May 25, 1951, P.L.417, No.99 and July 19, 1951, P.L.1100, No.245)

(d) The provisions contained in clauses one, four, eight and ten of subsection (a) of section six hundred and eighteen (618) may be omitted from ticket policies sold only to passengers by common carriers. ((d) amended May 25, 1951, P.L.417, No.99)

(e) Nothing in subdivision (b) of this article shall apply to nor in any way affect any insurance of medical, hospital, surgical and funeral expenses and disability and death benefits issued with and supplemental to a liability insurance policy as mentioned in paragraph four of subsection (c) of section two hundred two of this act. ((e) amended May 11, 1955, P.L.52, No.24)

Section 630. Preferred Provider Organizations.—Upon compliance with the provisions of this act and notwithstanding any other provision of law to the contrary, the General Assembly hereby affirms the right of any health care insurer, fraternal benefit society or purchaser to:

(a) Enter into agreements with providers or physicians relating to health care services which may be rendered to persons for whom the insurer or purchaser is providing health care coverage, including agreements relating to the amounts to be charged by the provider or physician for services rendered.

(b) Issue or administer policies or subscriber contracts in this Commonwealth which include incentives for the covered person to use the services of a provider who has entered into an agreement with the insurer or purchaser.

(c) Issue or administer policies or subscriber contracts in this Commonwealth that provide for reimbursement for services only if the services have been rendered by a provider or physician who has entered into an agreement with the insurer or purchaser.

(d) The Insurance Commissioner shall determine that:

(1) A preferred provider organization which assumes financial risk is licensed as an insurer or fraternal benefit society in this Commonwealth, has adequate working capital and reserves, or is governed and regulated under the provisions of the Employee Retirement Income Security Act of 1974, referred to as ERISA (Public Law 93-406, 88 Stat. 829), and has filed a certificate to that effect with the Insurance Commissioner.

(2) Enrollee literature adequately discloses provisions, limitations and conditions of benefits available or that the
preferred provider organization is governed and regulated under
the provisions of ERISA and has filed a certificate to that
effect with the Insurance Commissioner.

(e) The Insurance Commissioner, in consultation with the
Secretary of Health, shall determine that arrangements and
provisions for preferred provider organizations which assume
financial risk which may lead to undertreatment or poor quality
care are adequately addressed by quality and utilization
controls and by a formal grievance system, unless the Insurance
Commissioner makes a prior determination that the preferred
provider organization is governed by and regulated under the
provisions of the Employee Retirement Income Security Act and
has filed a certificate to that effect with the Insurance
Commissioner.

(f) No preferred provider organization which assumes
financial risk may commence operations until it has reported
to the Insurance Commissioner and the Secretary of Health such
information as the Insurance Commissioner and the Secretary of
Health require in accordance with the duties required in this
section. If, after sixty days, either the Insurance Commissioner
or the Secretary of Health has not informed the preferred
provider organization of deficiencies, the preferred provider
organization may commence operations unless and until such time
as the Insurance Commissioner or the Secretary of Health has
identified significant deficiencies and such deficiencies have
not subsequently been corrected within sixty days of
notification.

(g) Any disapproval or order to cease operations issued in
accordance with this section shall be subject to appeal in
accordance with Title 2 of the Pennsylvania Consolidated
Statutes (relating to administrative law and procedure).

(h) Fraternal benefit societies operating under subsections
(a), (b) and (c) shall be subject to sections 616 through 632.
(630 amended May 27, 1994, P.L.246, No.34)

Compiler's Note: Section 14(b) of Act 159 of 1996 provided
that section 630(f) is repealed insofar as it provides
for the approval of rates and forms.

Section 631. Reimbursement for Cancer
Therapy.--(a) Whenever any individual or group health, sickness
or accident insurance policy or subscriber contract or
certificate issued by any entity subject to 40 Pa.C.S. Chs. 61
(relating to hospital plan corporations) and 63 (relating to
professional health services plan corporations), this act, or
the act of July 29, 1977 (P.L.105, No.38), known as the
"Fraternal Benefit Society Code," providing hospital or
medical/surgical coverage includes within their coverage
benefits for cancer chemotherapy and cancer hormone treatments
and services which have been approved by the United States Food
and Drug Administration for general use in treatment of cancer,
the covered individual shall be entitled to benefits for cancer
chemotherapy and cancer hormone treatments, whether performed
in a physician's office, in an outpatient department of a
hospital, in a hospital as a hospital inpatient or in any other
medically appropriate treatment setting.

(b) Nothing in this section shall serve to diminish the
benefits of any insured or subscriber in effect on the effective
date of this act, nor prevent the offering or acceptance of
benefits which exceed the minimum benefits required by this
section.
This section shall apply to those insurance policies, subscriber contracts or certificates issued or entered into on or after the effective date of this section.

Section 631.1. Coverage for Oral Chemotherapy Medications.--(a) Whenever a health insurance policy provides coverage that includes coverage for intravenously administered or injected chemotherapy medications which have been approved by the United States Food and Drug Administration for general use in the treatment of cancer, the policy shall not provide coverage or impose cost sharing for a prescribed, orally administered chemotherapy medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected chemotherapy medications.

(b) A health insurance policy shall not increase cost sharing for chemotherapy medications in order to avoid compliance with subsection (a). A health insurance policy may increase cost sharing for chemotherapy medications if an increase is applied generally to other medical or pharmaceutical benefits administered in a similar health care setting under the contract.

(c) The prohibitions in subsections (a) and (b) do not preclude a health insurance policy from requiring an enrollee to obtain prior authorization before orally administered chemotherapy medication is dispensed to the enrollee. As part of prior authorization, an insurer may consider the medical necessity and cost of oral chemotherapy medications compared with intravenously administered or injected chemotherapy medication.

(d) This section shall apply to a high deductible health plan, as defined in section 223(c)(2) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(c)(2)), only after the covered person's deductible has been satisfied for the year.

(e) This section shall apply to those health insurance policies issued or entered into or renewed on or after the effective date of this section.

(f) As used in this section:

"Chemotherapy medication" means a medication prescribed by a treating health care practitioner that is necessary to kill or slow the growth of cancerous cells.

"Cost sharing" means the cost to an individual insured under a health insurance policy according to any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirements imposed by the policy, contract or agreement.

"Health insurance policy" means any individual or group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by an entity subject to one of the following:

(1) This act.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.
Compiler's Note: See section 2 of Act 73 of 2016 in the appendix to this act for special provisions relating to application of law.

Section 632. Coverage for Mammographic Examinations.--All group or individual health or sickness or accident insurance policies providing hospital or medical/surgical coverage and all group or individual subscriber contracts or certificates issued by any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), this act, the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," the act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code," or an employe welfare benefit plan as defined in section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.) providing hospital or medical/surgical coverage shall also provide coverage for mammographic examinations. The minimum coverage required shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age. Prior to payment for a screening mammogram, insurers shall verify that the screening mammography service provider is properly licensed by the department in accordance with the act of July 9, 1992 (P.L.449, No.93), known as the "Mammography Quality Assurance Act." Nothing in this section shall be construed to require an insurer to cover the surgical procedure known as mastectomy or to prevent application of deductible or copayment provisions contained in the policy or plan.


Section 633. Mastectomy and Breast Cancer Reconstruction.--(a) (1) No health insurance policy delivered, issued, executed or renewed in this Commonwealth on or after the effective date of this section shall require outpatient care following a mastectomy performed in a health care facility.

(2) Policies described in clause (1) of this subsection shall provide coverage for inpatient care following a mastectomy for the length of stay that the treating physician determines is necessary to meet generally accepted criteria for safe discharge.

(3) Such policies shall also provide coverage for a home health care visit that the treating physician determines is necessary within forty-eight hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy.

(4) Coverage under this section shall, however, remain subject to any copayment, coinsurance or deductible amounts set forth in the policy.

(b) (1) Every health care policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by a health care insurer which provides coverage for the surgical procedure known as mastectomy shall also include coverage for:

(i) prosthetic devices;

(ii) physical complications including lymphedemas; and

(iii) reconstructive surgery incident to any mastectomy in a manner determined in consultation with the attending physician and the patient. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.
(2) Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(3) An insurer may not deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the health insurance policy solely for the purpose of avoiding the requirements of this act.

((b) amended June 28, 2002, P.L.480, No.81)

(c) This section shall not apply to the following types of policies:

(1) Accident only.
(2) Limited benefit.
(3) Credit.
(4) Dental.
(5) Vision.
(6) Specified disease.
(7) Medicare supplement.
(8) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.
(9) Long-term care or disability income.
(10) Workers' compensation.
(11) Automobile medical payment.

(d) (1) The term "health insurance policy" when used in this section means any individual or group health insurance policy, subscriber contract, certificate or plan which provides medical or health care coverage by any health care facility or licensed health care provider which is offered by or is governed under this act or any of the following:

(i) Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."
(iii) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."
(v) A nonprofit corporation subject to 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

(2) The term "insurer" when used in this section means any entity that issues an individual or group health insurance policy, contract or plan described under clause (1) of this subsection.

(3) The term "mastectomy" when used in this section means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(4) The term "prosthetic devices" when used in this section means the use of initial and subsequent artificial devices to replace the removed breast or portions thereof pursuant to an order of the patient's physician.

(5) The term "reconstructive surgery" when used in this section means a surgical procedure performed on one breast or both breasts following a mastectomy, as determined by the treating physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the mastectomy. The term "reconstructive surgery" shall include, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

(6) The term "symmetry between breasts" when used in this section means approximate equality in size and shape of the
nondiseased breast with the diseased breast after definitive reconstructive surgery on the diseased or nondiseased breast has been performed.

(633 added Nov. 4, 1997, P.L.492, No.51)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: Section 5 of Act 51 of 1997, which added section 633, provided that section 633 shall apply to all insurance policies, subscriber contracts and group insurance certificates issued under any group master policy delivered or issued for delivery on or after the effective date of section 633. Section 633 shall also apply to all renewals of contracts on any renewal date which is on or after the effective date of section 633.

Section 634. Reimbursement for Diabetic Supplies.--(a) Except to the extent already covered under another policy, any individual or group health, sickness and accident insurance policy, group health insurance plans/policies, and all other forms of managed/capitated care plans/policies or subscriber contract or certificate issued by any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code," or this act providing hospital or medical/surgical coverage shall provide coverage of the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. The benefits specified in this section may be provided through a combination of policies, contracts, certificates or riders, including major medical contracts.

(b) This section does not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS (Civilian Health and Medical Program for the Uniform Services) supplement, long-term care, disability income, workers' compensation or automobile medical payment.

(c) Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

(d) Diabetes outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed physician shall include:

(1) visits medically necessary upon the diagnosis of diabetes;

(2) visits under circumstances whereby a physician identifies or diagnoses a significant change in the patient's
symptoms or conditions that necessitates changes in a patient's self-management; and
(3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as medically necessary by a licensed physician.
(e) The coverage required under this section shall be subject to the annual deductibles, copayments or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract. ((e) amended Dec. 20, 2000, P.L.967, No.132)
(634 added Oct. 16, 1998, P.L.784, No.98)

Section 635. Hearing Aid Coverage.--Any insurer that underwrites Medicare or Medicaid insurance for insureds residing in this Commonwealth shall provide coverage in such insurance for a hearing aid sold in accordance with section 403 of the act of November 24, 1976 (P.L.1182, No.262), known as the "Hearing Aid Sales Registration Law."
(635 added Oct. 16, 1998, P.L.784, No.98)

Section 635.1. Mental Illness Coverage.--(a) As used in this section:
(1) "Serious mental illness" means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder.
(2) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to one (1) of the following:
(i) This act.
(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
(b) This section shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employes: Provided, That this section shall not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) supplement, long-term care, disability income, workers' compensation or automobile medical payment.
(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet at a minimum the following standards:
(1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;
(2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;
(3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;
(4) cost-sharing arrangements, including, but not limited to, deductibles and copayments for coverage of serious mental illnesses, shall not prohibit access to care. The department
shall set up a method to determine whether any cost-sharing arrangements violate this subsection.

(d) The Legislative Budget and Finance Committee shall undertake a study of the cost and benefits of this section eighteen (18) months after the effective date of this section. The committee shall prepare a report of its study for the General Assembly on or before June 30, 2001, and every two years thereafter. Such study and report shall include, but not be limited to, an analysis of the following: the effect on policy premiums; the cost benefit of extending this act to all group health insurance policies offered in this Commonwealth; the cost benefit of this enhanced level of coverage for mental illness and the cost benefit to those employers who offer policies with more liberal benefits; the identity of employers who, after the effective date of this section, provide reduced mental health insurance benefits to employes and who provided more liberal mental health insurance benefits than provided in this act; an analysis of any mental illnesses enumerated under axis 1 of the Current Diagnostic and Statistical Manual of Mental Disorders not covered under this section, with specific consideration of whether any of them should be included in the definition of serious mental illness; actions taken by the department to assure health insurance policies are in compliance with this section and that quality and access to treatment for mental health conditions are not compromised by providing coverage under this section; identify any segments of this Commonwealth's population that may be excluded from access to treatment for mental health conditions; and an analysis of the use of medical services resulting from the provision of access to mental health treatment as provided by this section.

(1) The department shall fully cooperate and provide all nonconfidential data, records, reports and information that the committee may request in connection with this study.

(2) The study and report authorized in paragraph (1) must be actuarially sound and subject to peer review by the American Academy of Actuaries. Any assumptions upon which the study and the report are based must be common to the current health insurance market in Pennsylvania.

(635.1 added Dec. 21, 1998, P.L.1108, No.150)

Section 635.2. Autism Spectrum Disorders Coverage.--(a) A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders.

(b) Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. After December 30, 2011, the Insurance Commissioner shall, on or before April 1 of each calendar year, publish in the Pennsylvania Bulletin an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U) in the preceding year, and the published adjusted maximum benefit shall be applicable to the following calendar years to health insurance policies issued or renewed in those calendar years. Payments made by an insurer on behalf of a covered individual for treatment of a health condition unrelated to or distinguishable from the individual's autism spectrum disorder shall not be applied toward any maximum benefit established under this subsection.
(c) Coverage under this section shall be subject to copayment, deductible and coinsurance provisions and any other general exclusions or limitations of a health insurance policy or government program to the same extent as other medical services covered by the policy or program are subject to these provisions.

(d) This section shall not be construed as limiting benefits which are otherwise available to an individual under a health insurance policy or government program.

(d.1) This section shall not be construed as requiring coverage by insurers of any service based solely on its inclusion in an individualized education program. Consistent with Federal or State law and upon consent of the parent or guardian of the covered individual, the treatment of autism spectrum disorders may be coordinated with any service included in an individualized education program. Coverage for the treatment of autism spectrum disorders shall not be contingent upon a coordination of services with an individualized education program.

(e) (1) This section shall apply to any health insurance policy offered, issued or renewed on or after July 1, 2009, in this Commonwealth to groups of fifty-one (51) or more employees: Provided, That this section shall not include the following policies:

(i) Accident only.
(ii) Fixed indemnity.
(iii) Limited benefit.
(iv) Credit.
(v) Dental.
(vi) Vision.
(vii) Specified disease.
(viii) Medicare supplement.
(ix) CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) supplement.
(x) Long-term care or disability income.
(xi) Workers' compensation.
(xii) Automobile medical payment.

(2) This section shall apply to any contract executed on or after July 1, 2009, by the adult basic coverage insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act," or by the Children's Health Care Program established under this act, or by any successor program of either of them.

(3) On January 1, 2011, insurers shall make a report to the Insurance Department, in a form and manner as determined by the department, to evaluate the implementation of this section.

(f) As used in this section:

(1) "Applied behavioral analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(2) "Autism service provider" means any of the following:

(i) A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in this Commonwealth.

(ii) Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth's medical assistance program on or before the effective date of this section.
(3) "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

(4) "Behavior specialist" means an individual who designs, implements or evaluates a behavior modification intervention component of a treatment plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

(5) "Diagnostic assessment of autism spectrum disorders" means medically necessary assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

(6) "Government program" means any of the following:

(i) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

(ii) The adult basic coverage insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act."

(iii) The Children's Health Care Program established under this act.

(7) "Health insurance policy" means any group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by an entity subject to one of the following:

(i) This act.


(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(8) "Insurer" means any entity offering a health insurance policy as defined in this section.

(9) "Pharmacy care" means medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications.

(10) "Psychiatric care" means direct or consultative services provided by a physician who specializes in psychiatry.

(11) "Psychological care" means direct or consultative services provided by a psychologist.

(12) "Rehabilitative care" means professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

(13) "Therapeutic care" means services provided by speech language pathologists, occupational therapists or physical therapists.

(14) "Treatment of autism spectrum disorders" shall be identified in a treatment plan and shall include any of the following medically necessary pharmacy care, psychiatric care,
psychological care, rehabilitative care and therapeutic care that is:

(i) Prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner.
(ii) Provided by an autism service provider.
(iii) Provided by a person, entity or group that works under the direction of an autism service provider.

(15) "Treatment plan" means a plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

(g) (1) The State Board of Medicine, in consultation with the Department of Public Welfare, shall promulgate regulations providing for the licensure or certification of behavior specialists. Behavior specialists licensed or certified by the State Board of Medicine shall be subject to all disciplinary provisions applicable to medical doctors as set forth in the act of December 20, 1985 (P.L.457, No.112), known as the "Medical Practice Act of 1985." The State Board of Medicine may charge reasonable fees as set by board regulation for licensure or certificates or applications permitted by the "Medical Practice Act of 1985."

(2) An applicant applying for a license or certificate as a behavior specialist shall submit a written application on forms provided by the State Board of Medicine evidencing and insuring to the satisfaction of the board that the applicant:
(i) Is of good moral character.
(ii) Has received a master's or higher degree from a board-approved, accredited college or university, including a major course of study in school, clinical or counseling psychology, special education, social work, speech therapy, occupational therapy or another related field.
(iii) Has at least one year of experience involving functional behavior assessments, including the development and implementation of behavioral supports or treatment plans.
(iv) Has completed at least one thousand (1,000) hours in direct clinical experience with individuals with behavioral challenges or at least one thousand (1,000) hours' experience in a related field with individuals with autism spectrum disorders.
(v) Has completed relevant training programs, including professional ethics, autism-specific training, assessments training, instructional strategies and best practices, crisis intervention, comorbidity and medications, family collaboration and addressing specific skill deficits training.

(3) The board shall not issue a license or certificate to an applicant who has been convicted of a felony under the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act," or if an offense under the laws of another jurisdiction which, if committed in this Commonwealth, would be a felony under "The Controlled Substance, Drug, Device and Cosmetic Act," unless:
(i) At least ten (10) years have elapsed from the date of conviction.
(ii) The applicant satisfactorily demonstrates to the board that he has made significant progress in personal rehabilitation since the conviction such that licensure of the applicant should not be expected to create a substantial risk of harm to the
health and safety of his patients or the public or a substantial risk of further criminal violations.

(iii) The applicant otherwise satisfies the qualifications contained in or authorized by this section. As used in this paragraph, the term "convicted" shall include a judgment, an admission of guilt or a plea of nolo contendere.

(h) An insurer shall be required to contract with and to accept as a participating provider any autism service provider within its service area and enrolled in the Commonwealth's medical assistance program who agrees to accept the payment levels, terms and conditions applicable to the insurer's other participating providers for such service.

(i) An insurer may review a treatment plan for treatment of autism spectrum disorders once every six (6) months, subject to its utilization review requirements, including case management, concurrent review and other managed care provisions. A more or less frequent review can be agreed upon by the insurer and the licensed physician or licensed psychologist developing the treatment plan.

(j) For purposes of this section, the results of a diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than twelve (12) months unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

(k) (1) Upon denial or partial denial by an insurer of a claim for diagnostic assessment of autism spectrum disorders or a claim for treatment of autism spectrum disorders, a covered individual or an authorized representative shall be entitled to an expedited internal review process pursuant to the procedures set forth in Article XXI, followed by an expedited independent external review process established and administered by the Insurance Department.

(2) An insurer or covered individual or an authorized representative may appeal to a court of competent jurisdiction an order of an expedited independent external review disapproving a denial or partial denial. Pending a ruling of such court, the insurer shall pay for those services, if any, that have been authorized or ordered until such ruling.

(3) The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this subsection.

(l) For purposes of this section, the term "autism service provider" shall include any behavior specialist in this Commonwealth providing treatment of autism spectrum disorders pursuant to a treatment plan until one (1) year from the time that regulations under subsection (g) are promulgated or until three (3) years from the effective date of this section, whichever is later.

(635.2 added July 9, 2008, P.L.885, No.62)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.
Section 635.3. Coverage for Colorectal Cancer Screening.--(a) Except to the extent already covered under another policy, all health insurance policies as defined in this section shall also provide coverage for colorectal cancer screening for covered individuals in accordance with American Cancer Society guidelines for colorectal cancer screening published as of January 1, 2008, and consistent with approved medical standards and practices.

(1) Coverage for nonsymptomatic covered individuals who are fifty (50) years of age or older shall include, but not be limited to:
   (i) An annual fecal occult blood test.
   (ii) A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.
   (iii) A colonoscopy at least once every ten (10) years.

(2) Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating physician.

(3) Coverage for nonsymptomatic covered individuals who are at high or increased risk for colorectal cancer who are under fifty (50) years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008.

(b) The coverage required under this section shall be subject to annual deductibles, coinsurance and copayment requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(c) For the purpose of this section:
   (1) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate offered to groups of fifty-one (51) or more employees issued by an entity subject to any one of the following:
      (i) This act.
      (iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
   The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.
   (2) "Colonoscopy" means an examination of the rectum and the entire colon using a lighted instrument called a colonoscope.
   (3) "Colorectal cancer screening" means any of the following procedures that are furnished to an individual for the purpose of early detection of colorectal cancer:
      (i) Screening fecal-occult blood or fecal immunochemical test.
      (ii) Screening flexible sigmoidoscopy.
      (iii) Screening colonoscopy.
      (iv) Screening barium enema.
      (v) Screening test consistent with approved medical standards and practices to detect colon cancer.
“Nonsymptomatic person at high or increased risk” means an individual who poses a higher than average risk for colorectal cancer according to the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

“Symptomatic person” means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

(635.3 added July 9, 2008, P.L.885, No.62)

Compiler’s Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 635.4. Mini-COBRA Small Employer Group Health Policies.--(a) A group policy in effect or delivered or issued for delivery in this Commonwealth on or after the effective date of this section by an insurer which insures employees and their eligible dependents for hospital, surgical or major medical insurance shall provide that covered employees, or eligible dependents whose coverage under the group policy would otherwise terminate because of a qualifying event, shall be entitled to continue their hospital, surgical or major medical coverage under that group policy subject to the following terms and conditions:

(1) Continuation shall only be available to a covered employee or eligible dependent who has been continuously insured under a group policy, or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the group policy must be reinstated for the covered employee and any eligible dependents who were covered under continuation.

(2) Continuation shall not be available for any person covered under the group policy who:

(i) is covered or is eligible for coverage under Medicare;

(ii) fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent; or

(iii) is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination, excluding the medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," the children's health care program established under Article XXIII or the adult basic coverage insurance program established under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act," and any successors thereto.

(3) Continuation must include any benefits provided under the group policy.

(4) (i) The group policy shall provide notice to the policyholder of the rights provided under this section. Unless already provided in the group policy, an insurer who has issued a group policy in effect as of the effective date of this section shall provide such notice to the policyholder within forty-five days of the effective date.

(ii) The employer of a covered employee under a group policy must notify the administrator or its designee, the covered employee and the insurer of a qualifying event within thirty days.
days of the qualifying event. Notice to the covered employe shall include notice of the rights set forth in this section.

(iii) Each covered employe or eligible dependent shall notify the administrator or its designee of its election of continuation coverage under this section within thirty days of notice under subparagraph (ii). The coverage shall be effective as of the date of the qualifying event and shall be the same as the coverage in effect at the time of the qualifying event or any replacement coverage.

(iv) An administrator or its designee notified under subparagraph (iii) of an election of continuation coverage shall notify the insurer within fourteen days of the covered employe's or eligible dependent's election.

(v) Except as otherwise specified in an election, any election of continuation coverage by an eligible dependent shall be deemed to include an election of continuation coverage on behalf of any other eligible dependent who would lose coverage under the plan by reason of the qualifying event.

(5) (i) The covered employe or eligible dependent requesting the continuation of coverage must pay to the administrator or its designee, on a monthly basis, the amount of contribution required to be paid by the covered employe or eligible dependent to continue the coverage.

(ii) The premium contribution may not be more than one hundred five percent of the group rate of the insurance being continued on the due date of each payment.

(iii) Nothing in this section shall require the employer to contribute to the deductible of the employe holding a health savings account as defined in the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 223(d)) or other medical spending account as a component of the group policy after the termination date as long as scheduled payments have been made.

(6) (i) Continuation of coverage under the group policy for any covered employe or eligible dependent shall terminate upon failure to satisfy paragraph (2) or, if earlier, at the first to occur of the following:

(A) The end date, determined as the later of the following:

(I) nine months after the date the covered employe's or eligible dependent's coverage under the group policy would have terminated because of a qualifying event; or

(II) if, during the pendency of a covered employe's or dependent's receipt of continuation of coverage under a group policy, the department publishes a notice in the Pennsylvania Bulletin stating that a Federal premium assistance program is in existence, including premium assistance under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, 123 Stat. 115) or any successor extension act, the maximum number of months for which the program would make premium assistance available to the covered employe or eligible dependent because of the qualifying event, taking into account all prior months of the continuation of coverage from and after the date of the qualifying event.

(B) If the employe or member fails to make timely payment of a required premium contribution, the end of the period for which contributions were made.

(C) The date on which the group policy is terminated.

((i) amended July 9, 2010, P.L.362, No.51)

(ii) A covered employe or eligible dependent shall provide written notice to the administrator or its designee within fourteen days if, pursuant to paragraph (2), coverage should not occur.
(b) A covered employe shall be entitled to obtain a conversion policy as stated in section 621.2. The right to a converted policy pursuant to this act for a covered employe or eligible dependent entitled to continuation of coverage under this act shall commence upon termination of the continued coverage provided for under this act.

(c) Coverage as required by this section may not be conditioned upon or discriminated on the basis of lack of evidence of insurability.

(d) In the case of a qualifying event consisting of the involuntary termination of the covered employe's employment occurring on or after the effective date of this section and before January 1, 2010, or such other date as specified by any amendment to or successor of section 3001 of Division B, Title III of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, 123 Stat. 115), a covered employe or eligible dependent shall be entitled to premium assistance as provided in section 3001 of Division B, Title III of the American Recovery and Reinvestment Act of 2009, pursuant to the procedures and requirements set forth therein.

(e) This section shall only apply to those persons who satisfy both of the following criteria:


(2) Persons, and the eligible dependents of such persons, who are employed by an employer that normally employed between two and nineteen employes on a typical business day during the preceding year.

(f) The department may promulgate regulations as necessary for the implementation and administration of this section.

(g) For purposes of this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

(1) "Administrator" means the person specifically designated by an employer by written agreement to manage the administration of a group policy issued to an employer or, if an administrator is not so designated, the employer.

(2) "Covered employe" means an individual who is or was provided coverage under a group policy by virtue of the performance of services by the individual for one or more persons maintaining the policy, including as an employe defined in section 401(c)(1) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 401(c)(1)). Such term includes employes and members as those terms are used in section 621.2.

(3) "Eligible dependent" means:

(i) With respect to a covered employe under a group health plan, any other individual who on the day before the qualifying event for that employe is a beneficiary under the plan:

(A) as the spouse of the covered employe; or

(B) as the dependent child of the employe.

(ii) In the case of a qualifying event described in paragraph (6)(ii), the term includes a covered employe.

(iii) In the case of a qualifying event described in paragraph (6)(vi), the term includes a covered employe who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan:
(A) as the spouse of the covered employe;
(B) as the dependent child of the employe; or
(C) as the surviving spouse of the covered employe.
The term shall also include a child who is born to or placed for adoption with a covered employe during the period of continuation coverage under this section.

(4) "Group policy" means any group health insurance policy, subscriber contract, certificate or plan which provides health or sickness and accident coverage which is offered by an insurer. The term shall not include any of the following:
   (i) An accident only policy.
   (ii) A credit only policy.
   (iii) A long-term care or disability income policy.
   (iv) A specified disease policy.
   (v) A Medicare supplement policy.
   (vi) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.
   (vii) A fixed indemnity policy.
   (viii) A dental only policy.
   (ix) A vision only policy.
   (x) A workers' compensation policy.
   (xi) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).
   (xii) Any other similar policies providing for limited benefits.

(5) "Insurer" means a company or health insurance entity licensed in this Commonwealth to issue any health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under Article XXIV or other provision of this act or any of the following:
   (ii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(6) "Qualifying event" means, with respect to any covered employe, any of the following events which, but for the continuation of coverage required under this section, would result in the loss of coverage of an eligible dependent:
   (i) The death of a covered employe.
   (ii) The termination, other than by reason of such employe's gross misconduct, or reduction of hours of the covered employe's employment.
   (iii) The divorce or legal separation of the covered employe from an eligible dependent.
   (iv) The covered employe becoming entitled to benefits under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seg.).
   (v) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
   (vi) A proceeding in a case under 11 U.S.C. (relating to bankruptcy), with respect to the employer from whose employment the covered employe retired at any time. In the case of an event described in this subparagraph, a loss of coverage includes a substantial elimination of coverage with respect to an eligible dependent within one year before or after the date of commencement of the proceeding.

(635.4 added June 10, 2009, P.L.5, No.2)
Section 635.5. Continuation of Coverage Reinstatement.-- Subject to the limitations of section 635.4(a)(2) and the requirements of this section, a covered employe or eligible dependent whose continuation of coverage terminated upon the expiration of a period of months as provided in section 635.4(a)(6)(i)(A) prior to the effective date of this section shall have the right to reinstate continuation of coverage for an additional period of six months commencing on the effective date of this section. Reinstatement shall be available to the covered employees and dependents under the same terms and conditions applicable to covered employees and covered dependents who lost coverage under a plan due to a qualifying event on the effective date of this section, including the notice and election procedure described in section 635.4(a)(4)(ii), (iii), (iv) and (v) and the premium contribution requirements of section 635.4(a)(5).

(635.5 added July 9, 2010, P.L.362, No.51)

Compiler's Note: Section 10(2) Act 51 of 2010, which added section 635.5, provided that section 635.5 shall apply retroactively to July 10, 2009.

Section 635.6. Coverage of Prescriptions.--(a) A health insurance policy or government program providing benefits for prescriptions shall not impose on a covered individual utilizing a retail pharmacy a copayment, deductible, fee, limitation on benefits or other condition or requirement not otherwise imposed on the covered individual when using a mail-order pharmacy.

(b) Subsection (a) shall apply only if the retail pharmacy is willing to accept from the insurer the same pricing, terms, conditions or requirements related to the cost of the prescriptions and the cost and quality of dispensing prescriptions that the insurer has established for a mail-order pharmacy and any of such pharmacy's affiliates, including any affiliated pharmacy benefit manager, pursuant to the health insurance policy.

(c) Beginning eighteen months after the effective date of this section, the Legislative Budget and Finance Committee shall conduct an evaluation of the impact of this section regarding the access to prescription drugs at both independent and chain retail pharmacies and whether the provisions of this section have had a material positive or negative impact upon the cost of prescription medications to consumers and health care plans and shall issue a report to the General Assembly within nine months of the commencement of the study regarding its findings and recommendations.

(d) As used in this section:

(1) "Government program" means any of the following:
   (i) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."
   (ii) The Children's Health Care Program established under Article XXIII.
   (iii) The program of pharmaceutical assistance for the elderly established under Chapter 5 of the act of August 26, 1971 (P.L.351, No.91), known as the "State Lottery Law."
   (2) "Health insurance policy" means a group or individual health or sickness or accident insurance policy, subscriber
contract or certificate issued by an entity subject to any one of the following:

(i) This act.


(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

(3) "Insurer" means any entity that issues a group or individual health, sickness or accident policy or subscriber contract described under paragraph (2).

(4) "Mail-order pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act," where prescriptions are dispensed to covered individuals via the mail.

(5) "Prescription" and "dispensing" mean those terms as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act."

(6) "Retail pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act."

(635.6 added Nov. 1, 2012, P.L.1670, No.207)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: Section 2 of Act 207 of 2012, which added section 635.6, provided that Act 207 shall apply to all health insurance policies and government plans issued or renewed on or after the effective date of section 2.

Section 635.7. Billing.--(a) When an EMS agency is dispatched by a public safety answering point as defined in 35 Pa.C.S. § 5302 (relating to definitions) or an EMS agency dispatch center under 35 Pa.C.S. § 8129(i) (relating to emergency medical services agencies) for an emergency and provides medically necessary emergency medical services, a payment made by an insurer for a claim covered under and in accordance with a health insurance policy for an emergency medical service performed by the EMS agency during the call shall be paid directly to the EMS agency.

(b) An insurer must reimburse a nonnetwork EMS agency under the following:

(1) The EMS agency has submitted a completed standardized form to the department requesting nonnetwork direct reimbursement from an insurer an EMS agency has identified. The form must be submitted to the department annually by October 15. The form shall declare the EMS agency's intention to receive direct payment from an insurer identified on the form for the next calendar year. The department shall develop a standardized form, using an EMS agency's assigned license number, to be used by an EMS agency that meets the conditions established under this section. The department shall develop and maintain a publicly accessible electronic registry that indicates which
An EMS agency has requested nonnetwork direct reimbursement from an insurer identified on the form.

(2) An EMS agency has provided notification to the insurer upon submitting a claim for reimbursement that the EMS agency is registered with the department to receive direct reimbursement as provided for under this section.

(c) An EMS agency may be subject to periodic audits by an insurer to examine claims for direct reimbursement under this section. If, through the audit, the insurer identifies an improper payment, the insurer may deduct the improper payment from future reimbursements.

(d) Where an insurer has reimbursed a nonnetwork EMS agency at the same rate it has established for a network EMS agency, the EMS agency may not bill the insured directly or indirectly or otherwise attempt to collect from the insured for the service provided, except for a billing to recover a copayment, coinsurance or deductible as specified in the health insurance policy.

(e) An EMS agency that submits a form under this section may solicit donations or memberships or conduct fundraising, except that an EMS agency may not promise, suggest or infer to donors that a donation will result in the donor not being billed directly for any payment as provided under this section. Notwithstanding this paragraph, an EMS agency may bill in accordance with subsection (d). A violation of this section shall be considered a violation of the act of December 17, 1968 (P.L.1224, No.387), known as the "Unfair Trade Practices and Consumer Protection Law."

(f) Claims paid under this section shall be subject to section 2166.

(g) This section shall apply only to an EMS agency that is a nonnetwork provider and provides emergency medical services, unless preempted by Federal law.

(h) The following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:
   "Department." Department of Health of the Commonwealth.
   "EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions).
   "Emergency medical services." As defined in 35 Pa.C.S. § 8103 (relating to definitions).
   "Insurer." As follows:
   (1) An entity that is responsible for providing or paying for all or part of the cost of emergency medical services covered by an insurance policy, contract or plan. The term includes an entity subject to:
      (i) section 630, Article XXIV or any other provision of this act;
      (ii) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; or
      (iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
   (2) The term does not include an entity that is responsible for providing or paying under an insurance policy, contract or plan which meets any of the following:
      (i) Is a homeowner's insurance policy.
      (ii) Provides any of the following types of insurance:
         (A) Accident only.
         (B) Fixed indemnity.
         (C) Limited benefit.
         (D) Credit.
Section 636. Employers' Mutual Liability Insurance Associations Defined.--An incorporated association or company heretofore or hereafter formed by employers for the purpose of insuring themselves, and such other employers as may become subscribers to the association, against liability under the terms of articles two and three of "The Workmen's Compensation Act of one thousand nine hundred and fifteen," or any amendments or supplements or revisions thereof, shall be known as an "employers' mutual liability insurance association."

Section 637. Examination of Premises, Books, Et. Cetera.--The board of directors of any employers' mutual liability insurance association shall be entitled to inspect the plant, workroom, shop, farm, or premises of any subscriber, and, for such purpose, may appoint inspectors, who shall have free access to all such premises during the regular working hours. The board of directors shall likewise, from time to time, be entitled to examine, by their auditor or other agent, the books, records, and payrolls of any subscriber for the purposes of determining the amount of premium chargeable to such subscriber.

Section 638. Rules and Regulations; Refusal and Forfeiture of Insurance.--The board of directors of any such association shall make reasonable rules and regulations for the prevention of injuries upon the premises of subscribers; and they may refuse to insure, or may terminate the insurance of, any subscriber who refuses to permit such examination or disregards such rules and regulations, and forfeit one-half of the unearned premiums previously paid by him. Such termination of the insurance of any subscriber shall not release him from liability for the payment of assessments then or thereafter made by the board of directors to make up deficiencies existing at the termination of his insurance.

Section 639. Premiums.--The board of directors of any employers' mutual liability insurance association shall determine the amount of the premiums which the subscribers of the association shall pay for their insurance, in accordance with the nature of the business in which such subscribers are engaged, and the probable risk of injury to their employes under existing conditions. They shall fix premiums at such amounts as, in their judgment (subject to the approval of the Insurance Commissioner), shall be sufficient to enable the association to create and maintain the surplus provided in section six hundred and forty-three (643) of this act, and to pay to its subscribers all sums which may become due and payable to their employes under the provisions of article three of "The Workmen's Compensation Act of one thousand nine hundred and fifteen," or
any amendment or revision thereof, and also the expenses of conducting the business of the association.

In fixing the premium payable by any subscriber, the board of directors may take into account the condition of all the property or premises of such subscriber, in respect to the safety of those employed therein or thereon, as shown by the report of any inspector appointed by such board.

The board of directors may, from time to time, change the amount of premiums payable by any of the subscribers as circumstances may require, and the condition of the property or premises of such subscriber in respect to the safety of their employs may justify. They may increase the premiums of any subscriber neglecting to provide safety devices required by law, or disobeying the rules or regulations made by the board of directors in accordance with the provisions of section six hundred and thirty-eight (638) of this act.

No policy of insurance issued to any subscriber shall be effective until he shall have paid the premium so fixed and determined.

Section 640. Division of Subscribers into Groups.--The board of directors of such associations may divide the subscribers into groups, in accordance with the nature of their business and the probable risks of injury therein. In such case they shall fix all premiums for each business in such group, and for the various classes of employment therein, in accordance with the probable risks of injury to the employs in such business and in each class of employment therein; and they shall make all assessments, and determine and pay all dividends, by and for each group in accordance with the experience thereof; but all funds of the association and the contingent liability of all the subscribers shall be available for the payment of any claim against the association: Provided, however, That (as between the association and its subscribers) until the whole of the contingent liability of the members of any group shall be exhausted, the general funds of the association and the contingent liability of the members of other groups shall not be available for the payment of losses and expenses incurred by such group in excess of the earned premiums paid by the members thereof.

Section 641. Insurance Commissioner to Approve Premiums, Dividends, Et. Cetera.--Every employers' mutual liability insurance association shall file a statement of any proposed premium, assessment, dividend, or distribution of subscribers into groups with the Insurance Department, which shall not take effect until approved by the Insurance Commissioner.

Section 642. Dividends.--The board of directors of any employers' mutual liability insurance association may, from time to time, fix and determine the amount to be paid as dividends upon policies expiring each year, after retaining the unearned premiums upon undetermined risks and sufficient sums to pay all the compensation then payable or which may become payable on account of injuries theretofore received by employes of the subscribers, and to pay the expenses incurred in the operation of the business of the association, and such percentage of the premiums as have been paid or are payable to create and maintain the surplus provided in section six hundred and forty-three (643).

Section 643. Surplus.--The board of directors may set aside such part of all premiums collected as it may deem necessary for the creation of an adequate surplus to cover the catastrophe hazard of all the subscribers to such fund and to guarantee the solvency of the fund.
Section 644. Contingent Mutual Liability of Subscribers.--Every subscriber to such association shall be under a contingent mutual liability for the payment of losses and expenses in excess of the cash funds of the association to an amount at least equal to the premium paid by him during the current year.

Section 645. Assessments.--If any employers' mutual liability insurance association is not possessed of cash funds, over and above its unearned premiums on undetermined risks, sufficient for the payment of incurred losses and expenses, it shall make an assessment for the amount needed to pay such losses and expenses upon the subscribers liable to assessment therefor, in proportion to their several liabilities.

Section 646. Withdrawal of Subscribers.--Any subscriber of any employers' mutual liability insurance association who has complied with all of its rules and regulations may withdraw therefrom by written notice to that effect, sent by such subscriber by registered mail to the association. Such withdrawal shall become effective on the first day of the month immediately following the tenth day after the receipt of such notice. Such withdrawal shall not release such subscriber from liability for the payment of assessments thereafter made by the board of directors to make up deficiencies existing at the date of his withdrawal, provided assessment therefor is made within one calendar year from date of withdrawal; and such subscriber shall be entitled to his share of any dividend earned at the date of his withdrawal.

Section 647. Penalty.--If any officer of the employers' mutual liability insurance association shall falsely make oath to any certificate required to be filed with the Insurance Commissioner, he shall be guilty of perjury.

(d) WORKMEN'S COMPENSATION INSURANCE.

Section 651. Policy Provisions.--Every policy of insurance against liability under "The Workmen's Compensation Act of nineteen hundred and fifteen," and acts amendatory thereof or supplementary thereto, or under "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, shall contain the agreement of the insurer to pay all compensation and provide all medical, surgical, and hospital attendance for which the insured employer may become liable under such acts during the term of such insurance, and the further agreement that, as between the insurer and any claimant under such acts, notice to the employer or the employer's knowledge of an accident or injury or disability caused by occupational disease constituting the basis of a claim under such acts shall be notice to and knowledge of the insurer. Such agreements shall be construed to be a direct promise to the injured employee or to the dependents of a deceased employee having a claim under such acts, and shall be enforceable by action brought in the name of such injured employee or in the name of such dependents. Such obligation shall not be affected by any default of the insured, after an accident or after disability caused by occupational disease, in the payment of premiums or in the giving of any notices required by such policy or otherwise.

(651 amended July 2, 1953, P.L.342, No.79)

Section 652. Suits for Premiums.--No suit shall be maintained for the collection of premiums upon any policy of insurance under "The Workmen's Compensation Act of nineteen hundred and fifteen," and acts amendatory thereof or
supplementary thereto, or under "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, which violates any of the provisions of this act. All premiums and interest charges on account of policies insuring employees against liability under this chapter, which may be due to the State Workmen's Insurance Fund, or any stock corporation or mutual association authorized to transact the business of insurance in this State, and all judgments recovered by the State Workmen's Insurance Fund, or any such insurance corporation or association, against any employer on actions brought under any such policy, shall be deemed preferred claims in all insolvency or bankruptcy proceedings, trustee proceedings for administration of estates, and receiverships, involving the employer liable therefor, or the property of such employer; provided, however, that claims for wages shall receive prior preference in all such proceedings.

(652 amended July 2, 1953, P.L.342, No.79)

Section 653. Prohibited Policy Provisions.--No policy of insurance against liability under "The Workmen's Compensation Act of nineteen hundred and fifteen," and acts amendatory thereof or supplementary thereto, or under "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, shall contain any limitation of the liability of the insurer to an amount less than that for which the insured employer may become liable under such acts during the term of such insurance. No such policy or contract of insurance, nor any agreement to deliver such insurance, shall be issued except upon a form approved by the Insurance Commissioner as complying with all the terms and provisions of this act. But a policy may be issued to a self insurer, qualified under section three hundred five of article three of "The Workmen's Compensation Act of nineteen hundred and fifteen," and acts amendatory thereof or supplementary thereto, or under section three hundred five of article three of "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, providing for the payment of any stated loss in excess of ten thousand dollars falling upon such self insurer, under the terms of the said acts, by reason of any single accident or by reason of any single occurrence resulting in disability from occupational disease.

Except for nonpayment of premiums, no policy of insurance issued or renewed against liability under the act of June 2, 1915 (P.L.736, No.338), known as "The Pennsylvania Workmen's Compensation Act," and acts amendatory thereof or supplementary thereto; or under the act of June 21, 1939 (P.L.566, No.284), known as "The Pennsylvania Occupational Disease Act," and acts amendatory thereof or supplementary thereto; or under the Federal Coal Mine Health and Safety Act of 1969, as amended, Pub.L.91-173, December 30, 1969, 83 Stat. 742 et seq.; or insuring an employer against liability for all sums such employer shall become legally obligated to pay any employee of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employee arising out of and in the course of his employment, may be cancelled or terminated by an insurer during the term of the policy.

(653 amended Oct. 4, 1975, P.L.346, No.100)

Section 654. Classification of Risks; Underwriting Rules; Premium Rates; Schedule and Merit Rating Plans.--(a) The classification of risks, underwriting rules, premium rates,
and schedule or merit rating plans for insurance of employers and employees under "The Workmen's Compensation Act of nineteen hundred and fifteen," and acts amendatory thereof or supplementary thereto, and for insurance under "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, and for insurance with respect to the Commonwealth of Pennsylvania as to liability under "The United States Longshoremen's and Harbor Workers' Compensation Act" of one thousand nine hundred twenty-seven, and acts amendatory thereof or supplementary thereto, written as a part of a workmen's compensation and employers' liability policy, shall be proposed annually by one or more rating bureaus, said rating bureau or bureaus to be situated within the Commonwealth of Pennsylvania, subject to supervision and to examination by the Insurance Commissioner and approved by the Insurance Commissioner as adequately equipped to compile rates on an equitable and impartial basis. Such schedule or merit rating plans shall be applied only by the approved rating bureau or bureaus, and, in the preparation of schedules, no employer shall be discriminated against or penalized because of physical impairment of any employe or because of the number of dependents of any employe.

(b) The system of classification of risks, underwriting rules, premium rates and schedule or merit rating plans for insurance of employers and employees under such acts, shall be filed with, and shall be subject to review by the Insurance Commissioner, and the Insurance Commissioner shall by order modify, amend or approve the same. Any person, corporate or otherwise, aggrieved by such order, classification, rule, rate or schedule issued by the Insurance Commissioner may obtain a review thereof before the Insurance Commissioner.

(c) The assignment by an approved rating bureau of any individual risk to a particular classification in accordance with the system of classification of risks and underwriting rules approved by the Insurance Commissioner may be appealed by any person, corporate or otherwise, aggrieved by such assignment before the assigning bureau in accordance with procedures of the bureau approved by the Insurance Commissioner and, if still aggrieved by such reviewed assignment, such person may obtain a further review thereof by filing an appeal with the Insurance Commissioner within thirty days of the mailing date of the final decision of the bureau. The Insurance Commissioner shall hold a hearing upon not less than ten days written notice to the applicant and to the rating bureau which made such classification, and shall issue an order modifying, amending or approving the placement of the individual risk within the particular classification as the result of that hearing. Any order made by the Insurance Commissioner in accordance with this paragraph shall be appealable to the Commonwealth Court in accordance with Title 42 of the Pennsylvania Consolidated Statutes (relating to judiciary and judicial procedure).

(d) No risk classification system, underwriting rule, premium rate, or schedule or merit rating plan shall take effect without the consent of the Insurance Commissioner, and he may withdraw his approval whenever, in his judgment, the same is inadequate or discriminates unfairly between risks of essentially the same hazard.

(e) Neither the State Workmen's Insurance Fund, nor any insurance corporation, mutual association, or company, shall issue, renew, or carry any policy or contract of insurance against such liability under such acts, except in accordance
with the classifications, underwriting rules, premium rates, and schedule or merit rating plans, proposed by the rating bureau or bureaus aforesaid for the risk insured and as modified, amended or approved by the Insurance Commissioner for such insurer.

(f) Notwithstanding any other provisions of this section, upon the written consent of the insured stating his reasons therefor, filed with and approved by the Insurance Commissioner, a rate in excess of that determined in accordance with the other provisions of this section may be used on any specific risk.

(g) A complete copy of every policy or a true copy of the substantive provisions of any policy or contract of insurance against such liability under such acts, and a true copy of every endorsement upon any such policy and of every agreement pertaining thereto, shall be filed with the rating bureau or bureaus aforesaid within a reasonable time after the effective date of any such policy, endorsement, contract, or agreement.

(654 amended July 1, 1980, P.L.336, No.84)

Compiler's Note: Section 25(a) of Act 44 of 1993 provided that section 654 is repealed except with regard to insurance as to liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 23 U.S.C. § 901 et seq.).

Section 655. Annual Report of Premiums and Loss Experience; Penalties.--The State Workmen's Insurance Fund, and every insurance company and every employer's mutual liability association which insures employers and employes under "The Workmen's Compensation Act of one thousand nine hundred and fifteen," and acts amendatory thereof or supplementary thereto, or under "The Pennsylvania Occupational Disease Act of nineteen hundred and thirty-nine," and acts amendatory thereof or supplementary thereto, or with respect to Pennsylvania under the "United States Longshoremen's and Harbor Workers' Compensation Act" of one thousand nine hundred twenty-seven, and acts amendatory thereof or supplementary thereto, when such liability is insured as a part of a workmen's compensation and employers' liability policy, shall annually, on or before the thirtieth day of June, file with the Insurance Commissioner a sworn report of its premium and loss experience, in such detail and form as may be prescribed by the Insurance Commissioner. Any insurance carrier which neglects to make and file such statement in the form or within the time herein provided shall forfeit one hundred dollars for each day during which such neglect continues, and, upon notice by the Insurance Commissioner, its authority to do business shall cease while such default continues.

The Insurance Commissioner shall have the power to suspend or revoke the license of any insurance company which violates any of the provisions of subdivision (d) of this article.

(655 amended July 2, 1953, P.L.342, No.79)

(e) SURETY COMPANIES.

Section 661. Conditions for Doing Business.--Every surety company, to be qualified to so act as surety or guarantor, must be authorized, under the laws of the State or country where incorporated and its charter, to guarantee the fidelity of persons holding places of public or private trust, and to guarantee the performance of contracts other than insurance policies, and to execute bonds and undertakings required or permitted in action or proceedings or by law allowed, must: (a)
Comply with the requirements of the laws of this State applicable to such company in doing business therein; (b) must have at least one hundred thousand dollars ($100,000) invested in securities created by the laws of the United States, or by or under the laws of the State or country wherein it is incorporated, or in other safe, marketable, and interest-bearing stocks and securities, the value of which shall be at or above par and deposited with or held by the Insurance Commissioner or other corresponding officer of the State or country in which it is authorized to transact business, in trust for the benefit of the holders of the obligations of such company; (c) its liabilities must not exceed its available assets, which said liabilities, however, shall be taken to be---(I) its capital stock, (II) its outstanding debts, and (III) a premium reserved equal to fifty per centum of the annual premium on all outstanding risks in force; and (d) such company shall also, before transacting business in this State under this act, file with the Insurance Commissioner a certified copy of its charter or act of incorporation, (e) a written application to be authorized to do business under this act, and (f) a statement, signed and sworn to by its president or one of its vice presidents and its secretary, or one of its assistant secretaries, stating---(I) the amount of its paid up cash capital, (II) particularly each item of investment, (III) the amount of premium on existing bonds upon which it is surety, (IV) the amount of liability for unearned portion thereof, estimated at fifty per centum of the annual premium on all outstanding premiums for one year or less, and pro rata for terms of more than one year, and (V) the amount of its outstanding debts of all kinds.

Any surety company which is authorized to do business in this Commonwealth shall not expose itself to any loss or hazard on any one fidelity or surety risk in an amount exceeding ten per centum of its capital and surplus unless it shall be protected in excess of that amount by:

(a) Reinsurance in a corporation authorized to transact the fidelity or surety business in this State: Provided, That such reinsurance is in such form as to enable the obligee or beneficiary to maintain an action thereon against the company reinsured jointly with such reinsurer, and, upon recovering judgment against such reinsured, to have recovery against such reinsurer for payment to the extent in which it may be liable under such reinsurance and in discharge thereof; or

(b) The co-suretyship of such a corporation similarly authorized; or

(c) By deposit with it, in pledge or conveyance to it in trust, for its protection, of property; or

(d) By conveyance or mortgage for its protection; or

(e) In case a suretyship obligation was made on behalf or on account of a fiduciary holding property in a trust capacity, by deposit or other disposition of a portion of the property so held in trust that no future sale, mortgage, pledge, or other disposition can be made thereof without the consent of such corporation, except by decree or order of a court of competent jurisdiction.

Provided, (1) That such a corporation may execute what are known as transportation or warehousing bonds for United States internal revenue taxes to an amount equal to fifty per centum of its capital and surplus; (2) that, when the penalty of the suretyship obligation exceeds the amount of a judgment described therein as appealed from and thereby secured, or exceeds the amount of the subject matter in controversy or of the estate
in the hands of the fiduciary for the performance of whose duties it is conditioned, the bond may be executed if the actual amount of the judgment or the subject matter in controversy or estate not subject to supervision or control of the surety is not in excess of such limitation; and (3) that, when the penalty of the suretyship obligation executed for the performance of a contract exceeds the contract price, the latter shall be taken as the basis for estimating the limit of risk within the meaning of this section.

No such corporation shall, anything to the contrary in this section notwithstanding, execute suretyship obligations guaranteeing the deposits of any single financial institution in an aggregate amount in excess of ten per centum of the capital and surplus of such corporate surety, unless it shall be protected in excess of that amount by credits in accordance with subdivisions (a), (b), (c), or (d) of this section.

Upon satisfactory evidence of the violation of this section by any insurance company, association, or exchange, its members, officers, directors, or attorney-in-fact, the Insurance Commissioner shall, in his discretion, take, against the offending party, any one or more of the following courses of action: (1) Revoke the certificate of authority of such offending company, association, or exchange; (2) refuse, for a period of not to exceed one year thereafter, to issue a new license to such offending company, association, or exchange; (3) impose a fine of not more than one thousand dollars for each act of violation of said section. Any insurance company, or the officers, directors, members, or attorney-in-fact of any insurance company, association, or exchange, or any other person, violating any of the provisions of this section, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than five hundred dollars ($500.00) for each and every violation, or to imprisonment in the jail of the county in which the offense is committed for a period of not more than six (6) months or both. (Par. repealed in part Apr. 28, 1978, P.L.202, No.53)

(661 amended June 22, 1931, P.L.613, No.208)

Section 662. Certificate To Do Business.--If the Insurance Commissioner is satisfied that such company is solvent, and has the cash capital herein provided for and surplus assets in excess of its capital stock, its outstanding debts, and the premiums reserve specified, and that it has in all respects complied with and is qualified under this act, he shall issue to such company, and to each of its agents in this State, his certificate that it is authorized to become and be accepted as sole surety on all bonds, undertakings, and obligations required or permitted by law or the charter, ordinances, rules, or regulations of any municipality, board, body, organization, or public officer, which said certificate shall be conclusive proof of the solvency and credit of such company for all purposes and of its right to be so accepted as such sole surety and its sufficiency as such.

Section 663. Information To Be Furnished Annually.--Every such company shall also annually, in the month of January, file with the Insurance Commissioner a statement similar to that hereinbefore in section six hundred and sixty-one (661) provided for, and shall also furnish him with a certificate from the officer with whom the deposit herein mentioned is required to be made, describing such securities so deposited and the manner in which they are held by him, and stating that he is satisfied that such securities are fully worth one hundred thousand dollars ($100,000), and also shall furnish the Insurance
Commissioner with such other information touching the condition and credit of the company as he may require, signed and sworn to.

Section 664. Power to Execute Bonds, Et. Cetera.--Any surety company which is authorized to do business in this Commonwealth in accordance with the provisions of this act is authorized to execute any bond, recognizance, or other obligation which is required by law or by the charter, ordinances, rules, or regulations of any municipality, board, body, or public officer, to be given with surety or sureties. The execution by such company of any such bond, recognizance, or obligation shall be a full and complete compliance with every requirement of such law, charter, ordinance, or rule, and obligation, that such bond, obligation, or recognizance shall be executed by one or more sureties, or that such sureties shall be residents, householders, freeholders, or possess any other qualifications.

Section 665. Liability of Companies.--No surety company having signed a bond, undertaking, or obligation shall be permitted to deny its corporative power to execute such instruments or incur such liability in any proceeding to enforce liability against it thereunder.

Section 666. Guaranteed Arrest Bond Certificates Issued by Automobile Clubs or Associations.--(a) Any domestic or foreign insurance company which is authorized to transact surety business, pursuant to the act to which this is an amendment, may, in any year, become surety in an amount not exceeding two hundred dollars ($200) with respect to each of such guaranteed arrest bond certificates issued in the year by an automobile club or association or by an insurance company authorized to write automobile liability insurance within this State, by filing with the Insurance Commissioner an undertaking thus to become surety which shall be in form prescribed by the commissioner, and shall state the following:

(1) The names and addresses of the automobile clubs, automobile associations or insurance company or companies with respect to the guaranteed arrest bond certificates of which the surety company undertakes to be surety.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not exceeding two hundred dollars ($200), of any one person who, after posting a guaranteed arrest bond certificate with respect to which the surety company has undertaken to be surety, fails to make the appearance for which the guaranteed arrest bond certificate was posted.

(b) The term "guaranteed arrest bond certificate," as used herein, means any printed card or other certificate issued by an automobile club, association or insurance company to any of its members or insureds, which card or certificate is signed by the member or insured and contains a printed statement that the automobile club, association or insurance company and a surety company or an insurance company authorized to transact both automobile liability insurance and surety business, guarantee the appearance of the person whose signature appears on the card or certificate and that they will, in the event of failure of the person to appear in any court or before any magistrate, alderman or justice of the peace in this State, pay any fine or forfeiture imposed on the person in an amount not exceeding two hundred dollars ($200), when the person is arrested or formally charged for violation of any motor vehicle or traffic law of this State or ordinance of any local authority of this State pertaining thereto except as hereinafter set forth.
Compiler's Note: Section 28 of Act 207 of 2004 provided that any and all references in any other law to a "district justice" or "justice of the peace" shall be deemed to be references to a magisterial district judge.

Section 667. Use of Guaranteed Arrest Bond Certificates.--Any guaranteed arrest bond certificate with respect to which a surety company has become surety or a guaranteed arrest bond certificate issued by an insurance company authorized to transact both automobile liability insurance and surety business within this State, shall, when posted by the person whose signature appears thereon, be accepted in lieu of cash bail in an amount not exceeding two hundred dollars ($200) as a bail bond to guarantee the appearance of the person in any court or before any magistrate, alderman or justice of the peace in this State at such time as may be required by the court or magistrate, alderman or justice of the peace when the person is arrested or formally charged for violation of any motor vehicle or traffic law of this State or ordinance of any local authority pertaining thereto in this State, except for the offenses which are misdemeanors or felonies as defined in "The Vehicle Code." Any guaranteed arrest bond certificate posted as bail bond in any court in this State shall be subject to the forfeiture and enforcement provisions of law applicable to a bail bond.

(f) BOILER INSURANCE.

Section 671. Liability of Companies.--Companies incorporated under the laws of this State or doing business in this Commonwealth with power to insure against loss by the explosion of steam boilers, may insure all loss or damage which the owner or owners of said boiler, or their employes or other persons, may suffer or be liable for in case of an explosion of the boilers mentioned in any policy of insurance issued by such company for the amount specified therein.

(g) MUTUAL CASUALTY INSURANCE.

Section 675. Licensing of Foreign Mutual Casualty Insurance Companies.--A mutual casualty insurance company, organized under the laws of any other state or country, and having by its charter the power to transact the insurance business specified in section two hundred two, subdivision (c), in order to be licensed to transact the classes of business mentioned in section two hundred two, sub-paragraph (c) shall have a surplus over all liabilities, including unearned premium and loss reserves, of not less than the capital required of a domestic stock company to transact the same kinds of insurance.


ARTICLE VI-A.

BENEFITS FOR ALCOHOL ABUSE AND DEPENDENCY.

Compiler's Note: Section 5 of Act 53 of 1997 provided that nothing in Act 53 shall relieve, restrict or expand the obligations of any insurer, health maintenance organization, third-party administrators, hospital plan corporation or health services plan corporation doing business in this Commonwealth with respect to the coverage of drug and alcohol benefits, as set forth in Article VI-A.

Section 601-A. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Alcohol or drug abuse." Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of this act, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

"Detoxification." The process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

"Hospital." A facility licensed as a hospital by the Department of Health, the Department of Public Welfare, or operated by the Commonwealth and conducting an alcoholism or
drug addiction treatment program licensed by the Department of Health.

"Inpatient care." The provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a hospital or non-hospital facility, according to individualized treatment plans.

"Non-hospital facility." A facility, licensed by the Department of Health, for the care or treatment of alcohol-dependent or other drug-dependent persons, except for transitional living facilities.

"Non-hospital residential care." The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or other drug abuse or dependency in a residential environment, according to individualized treatment plans.

"Outpatient care." The provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.

"Partial hospitalization." The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as an alcoholism or drug addiction treatment program by the Department of Health, designed for a patient or client who would benefit from more intensive than are offered in outpatient treatment but who does not require inpatient care.


Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 602-A. Mandated Policy Coverages and Options.--(a) All group health or sickness or accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or Ch. 63 (relating to professional health services plan corporations), the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," or the act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 603-A, 604-A and 605-A.

(b) The benefits specified in subsection (a) may be provided through a combination of such policies, contracts or certificates.

(c) The benefits specified in subsection (a) may be provided through prospective payment plans.

(d) The provisions of subsection (a) shall not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies, such as, but not limited to, cancer insurance, polio insurance, dental care and similar policies as may be identified as exempt from this section by the Insurance Commissioner.


Section 603-A. Inpatient Detoxification.--(a) Inpatient detoxification as a covered benefit under this article shall be provided either in a hospital or in an inpatient non-hospital facility which has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological
support services, meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program.

(b) The following services shall be covered under inpatient detoxification:
(1) Lodging and dietary services.
(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(3) Diagnostic X-ray.
(4) Psychiatric, psychological and medical laboratory testing.
(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section may be subject to a lifetime limit, for any covered individual, of four admissions for detoxification and reimbursement per admission may be limited to seven (7) days of treatment or an equivalent amount.

Section 604-A. Non-hospital Residential Alcohol or Other Drug Services.--(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Office of Drug and Alcohol Programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:
(1) Lodging and dietary services.
(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(3) Rehabilitation therapy and counseling.
(4) Family counseling and intervention.
(5) Psychiatric, psychological and medical laboratory tests.
(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this act, for a minimum of thirty (30) days per year for residential care. Additional days shall be available as provided in section 605-A(d). Treatment may be subject to a lifetime limit, for any covered individual, of ninety (90) days.

Section 605-A. Outpatient Alcohol or Other Drug Services.--(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:
(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(2) Rehabilitation therapy and counseling.
(3) Family counseling and intervention.
(4) Psychiatric, psychological and medical laboratory tests.
(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this act for a minimum of thirty outpatient, full-session visits or equivalent partial visits per year. Treatment may be subject to a lifetime limit, for any covered individual, of one hundred and twenty outpatient, full-session visits or equivalent partial visits.

(d) In addition, treatment under this section shall be covered as required by this act for a minimum of thirty separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to fifteen additional non-hospital, residential alcohol treatment days.


Section 606-A. Deductibles, Copayment Plans and Prospective Pay.--(a) Reasonable deductible or copayment plans, or both, after approval by the Insurance Commissioner, may be applied to benefits paid to or on behalf of patients during the course of alcohol or other drug abuse or dependency treatment. In the first instance or course of treatment, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

(b) In the first instance or course of treatment under a prospective payment plan, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.


Section 607-A. Rules and Regulations.--The Insurance Commissioner and the Secretary of Health shall jointly promulgate those rules and regulations as are deemed necessary for the effective implementation and operation of this article.

(607-A added June 11, 1986, P.L.226, No.64)

Section 608-A. Preservation of Certain Benefits.--Nothing in this article shall serve to diminish the benefits of any insured or subscriber existing on the effective date of this article nor prevent the offering or acceptance of benefits which exceed the minimum benefits required by this act.

(608-A added June 11, 1986, P.L.226, No.64)

ARTICLE VI-B
HEALTH INSURANCE COVERAGE PARITY
AND NONDISCRIMINATION

Section 601-B. Short title of article.
This article shall be known and may be cited as the Health Insurance Coverage Parity and Nondiscrimination Act.


Section 602-B. Purpose.
It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth by implementing the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881), the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881) and Michelle's Law (Public Law 110-381, 122 Stat. 4081), collectively contained in the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 201 et seq.). The provisions of this article are intended to meet these requirements while retaining the Commonwealth's authority to regulate health insurance in
this Commonwealth, consistent with sections 2722 and 2761 of the Public Health Service Act.


Section 603-B. Definitions.

(a) General rule.--The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.


"Fraternal benefit society." An entity holding a current certificate of authority under Article XXIV.


"Hospital plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Insurer." A foreign or domestic insurance company, association or exchange, health maintenance organization, hospital plan corporation, professional health services plan corporation, fraternal benefit society or risk-assuming preferred provider organization. The term shall not include a group health plan as defined in section 2791 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-91).

"Preferred provider organization." An entity holding a current certificate of authority under section 630.

"Professional health services plan corporation." An entity holding a current certificate of authority under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations). This term shall not include dental service corporations or optometric service corporations, as those terms are defined under 40 Pa.C.S. § 6302(a) (relating to definitions).

(b) Federal law.--The words, terms and definitions found in the Federal acts, including those in section 2791 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 300gg-91), are adopted for purposes of implementing this article, except as noted in this subsection. The term "health insurance issuer" under section 2791(b)(2) of the Public Health Service Act shall have the meaning provided under "insurer" in subsection (a).

(603-B added Mar. 22, 2010, P.L.147, No.14)

Section 604-B. Adoption of Federal acts.

Insurers shall comply with the Federal acts as contained in sections 2701, 2702, 2705, 2707, 2721, 2753 and 2754 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. §§ 300gg, 300gg-1, 300gg-5, 300gg-7, 300gg-21, 300gg-53 and 300gg-54).


Section 605-B. Penalties.

(a) General rule.--Upon satisfactory evidence of a violation of this article by any insurer or other person, the commissioner may, in the commissioner's discretion, pursue any one of the following courses of action:

(1) Suspend, revoke or refuse to renew the license of the offending person.
(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than $5,000 for each action in violation of this article.

(4) Impose a civil penalty of not more than $10,000 for each action in willful violation of this article.

(b) Limitation.--Penalties imposed against a person under this article and under section 5 of the act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act, shall not exceed $500,000 in the aggregate during a single calendar year.

(605-B added Mar. 22, 2010, P.L.147, No.14)

Section 606-B. Regulations.
The department may promulgate such regulations as may be necessary or appropriate to carry out this article.

(606-B added Mar. 22, 2010, P.L.147, No.14)

ARTICLE VII.

TITLE INSURANCE COMPANIES.


Section 701. Definitions.--For the purpose of this article:

(1) "Title insurance" means insuring, guaranteeing or indemnifying against loss or damage suffered by owners of real property or by others interested therein by reason of liens, encumbrances upon, defects in or the unmarketability of the title to said real property; guaranteeing, warranting or otherwise insuring the correctness of searches relating to the title to real property; and doing any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this article.

(2) The "business of title insurance" shall be deemed to be (i) the making as insurer, guarantor or surety, or proposing to make as insurer, guarantor or surety, of any contract or policy of title insurance; (ii) the transacting, or proposing to transact, any phase of title insurance, including solicitation, negotiation preliminary to execution, execution of a contract of title insurance, insuring and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance; and (iii) the doing, or proposing to do, any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this article.

(3) "Title insurance company" means any domestic company organized under the provisions of this article for the purpose of insuring titles to real estate, a title insurance company organized under the laws of another state or foreign government and licensed to insure titles to real estate within this Commonwealth pursuant to section 722 of this article, domestic and foreign companies, including any domestic bank or trust company, having the power and authorized to insure titles to real estate within this Commonwealth as of the effective date of this amendment and which meet the requirements of section 710 of this article.

(4) "Applicant for insurance" shall be deemed to include approved attorneys, real estate brokers, real estate salesmen, attorneys at law and all others who from time to time apply to a title insurance company or to an agent of a title insurance company, for title insurance, and who at the time of such application are not agents for a title insurance company.

(5) "Fee" for title insurance means and includes the premium, the examination and settlement or closing fees, and
every other charge, whether denominated premium or otherwise, made by a title insurance company, agent of a title insurance company or an approved attorney of a title insurance company, or any of them, to an insured or to an applicant for insurance, for any policy or contract for the issuance of, or an application for any class or kind of, title insurance; but the term "fee" shall not include any charges paid by an insured or by an applicant for insurance, for any policy or contract, to an attorney at law acting as an independent contractor and retained by such attorney at law, whether or not he is acting as an agent of or an approved attorney of a title insurance company, or any charges made for special services not constituting title insurance, even though performed in connection with a title insurance policy or contract.

(6) "Commissioner" means the Insurance Commissioner of the Commonwealth of Pennsylvania.

(7) An "approved attorney" means an attorney at law in good standing upon whose examination of title and report of title thereon a title insurance company may issue a policy of title insurance.

Section 702. Application of Article.--The provisions of this article shall apply to all title insurance companies, title rating organizations, title insurance agents, applicants for title insurance, policyholders and to all persons and business entities engaged in the business of title insurance.

Section 703. Compliance with Article Required.--On and after the effective date of this amendment, only a title insurance company as defined in clause (3) of section 701 shall underwrite or issue a policy of title insurance; further, no person, firm, association, corporation, cooperative or joint-stock company shall engage in the business of title insurance in this Commonwealth unless authorized to transact such a business by the provisions of this article.

Section 704. Corporate Form Required.--A title insurance company shall be organized as a stock corporation as provided in sections 203 to 205, inclusive and 207 to 214, inclusive, of this act, and certified in the manner prescribed in section 215, except as hereinafter prescribed, to do the kind of insurance business, with incidental powers, specified in this article.

Section 705. Financial Requirements.--Every title insurance company shall have a minimum capital, which shall be paid in and maintained, of not less than five hundred thousand dollars ($500,000) and, in addition, paid-in initial surplus at least equal to fifty percent of its capital.

Section 706. Procedure When Capital Impaired.--If for any reason the capital of a title insurance company becomes impaired, such title insurance company shall forthwith give written notice thereof to the commissioner and shall make no further policies or contracts or reinsurance agreements of title insurance while such impairment exists. Such title insurance company shall immediately call upon its stockholders for such amounts as will restore its capital to an amount prescribed by the commissioner. In case any stockholder neglects or refuses to pay the amount called for, after notice personally given or by advertisement, at such time and in such manner as the commissioner shall approve, the title insurance company shall
require the return of the original certificate or certificates of stock held by such stockholder, and, in lieu thereof, issue new certificates in the proportion that the ascertained value of the assets may, as determined by the commissioner, bear to the capital existing immediately prior to the impairment, the title insurance company paying for any fractional parts of shares. The directors of the title insurance company, with the prior consent and approval of the commissioner, may create new stock, and issue certificates therefor, and dispose of the same, at not less than par, for an amount sufficient to make up the original capital or the commissioner may, in his discretion, permit the company to reduce its capital and the par value of its shares in proportion to the extent of the impairment, but the capital shall at no time be reduced to an amount less than that required by law for the organization of any such company. In fixing such reduced capital, not more than fifty percent of the original capital shall be deducted from the assets on hand to be retained as surplus funds, nor shall any part of assets be distributed to stockholders. When the amount of capital prescribed by the commissioner has been restored, the title insurance company shall so notify the commissioner who, upon being satisfied that the impairment no longer exists and is not likely to recur, shall give written approval authorizing the title insurance company to again issue such policies or contracts or reinsurance agreements of title insurance.


Section 707. Title Examination Required.--No policy of title insurance, excluding reinsurance, shall be written unless and until the title insurance company, either through its own employes, agents or approved attorneys, has conducted a reasonable examination of the record title or has caused a reasonable examination of title to be conducted. The abstract of title or the report of the examination thereof shall be in writing and shall be kept on file by the title insurance company or its agent or approved attorney for a period of not less than twenty years after the policy of title insurance has been issued. In lieu of retaining the original copy, the title insurance company or the agent of the title insurance company or the approved attorney of the title insurance company, may, in the regular course of business, establish a system whereby all or part of these writings are recorded, copied or reproduced by any photographic, photostatic, microfilm, micro-card, miniature photographic or other process which accurately reproduces or forms a durable medium for reproducing the original.


Section 708. Power to Insure Titles to Real Estate.--Every title insurance company shall have the power to make insurance of every kind pertaining to or connected with titles to real estate, and to make, execute and perfect such and so many contracts, agreements, policies and other instruments as may be required therefor, such insurances to be made for the benefit of owners of real estate, mortgagees and others interested in real estate, from loss by reason of defective titles, liens and encumbrances.


Section 709. Prohibition upon Guaranteeing Mortgages.--A title insurance company shall not, in any manner whatsoever, guarantee the payment of the principal or the interest of bonds or other obligations secured by mortgages upon real property.

Section 710. Power to Insure Titles to Real Estate; Loss of Power.--(a) Every title insurance company which upon the effective date of this amendment shall lawfully possess and which has within one year prior to such date lawfully exercised in this Commonwealth the power to insure owners of real property, mortgagees, and others interested in real property, and others from loss by reason of defective titles, liens and encumbrances, shall, subject to the conditions herein prescribed, continue to possess such power.

(b) Every title insurance company which does not hereafter exercise for any period of twelve months the power to insure owners of real property, mortgagees and others interested in real property, from loss by reason of defective titles, liens and encumbrances shall be forever barred from the exercise of such power.


Section 711. Power to Accept Deposits; Loss of Title Insurance Powers.--Any title insurance company which shall possess the further powers to receive deposits or otherwise to engage in a banking business, and shall not have exercised, within one year preceding the effective date of this amendment, any of such further powers, and shall again exercise such further powers to receive deposits or otherwise engage in a banking business, shall make no further contracts or issue any policies of title insurance. Any title insurance company possessing such further powers and shall not hereafter exercise any of such further powers for any consecutive period of one year, upon exercising again such further powers to receive deposits or otherwise engage in a banking business, shall make no further contracts or issue any policies of title insurance.


Section 712. Power to Act as a Fiduciary; Loss of Title Insurance Powers.--Any title insurance company which shall possess the further powers to act as trustee, guardian, executor, administrator, or in any other similar fiduciary capacity, and shall not have exercised, within one year preceding the effective date of this amendment, any of such further powers, and again shall exercise any of such further powers, shall make no further contracts or issue any policies of title insurance. Any such title insurance company possessing such further powers and which shall not hereafter exercise any of such further powers for any consecutive period of one year, upon exercising again any of such further powers shall make no further contracts or issue any policies of title insurance.


Section 713. Power of Title Insurance Company; Prohibition Against Transacting Other Kinds of Insurance; Prohibition Against Other Kinds of Insurance Companies Transacting Title Insurance.--A title insurance company shall not transact, underwrite or issue any kind of insurance other than title insurance; nor shall title insurance be transacted, underwritten or issued by any company transacting any other kinds of insurance.


Section 714. Unearned Premium Reserve.--(a) Every title insurance company shall, in addition to other reserves, establish and maintain a reserve to be known as the "unearned premium reserve" for title insurance, which shall, at all times for all purposes, be deemed and shall constitute the unearned portions of premiums due or received and shall be charged as a reserve liability of such title insurance company in determining its financial condition.
(b) The unearned premium reserve shall be retained and held by such title insurance company for the protection of the policyholders' interest in policies which have not expired. Except as provided in section 717 of this act, assets equal to the amount of such reserve shall not be subject to distribution among depositors or other creditors or stockholders of such title insurance company until all claims of policyholders or holders of other title insurance contracts or agreements of such title insurance company have been paid in full and all liability on the policies or other title insurance contracts or agreements, whether contingent or actual, has been discharged or lawfully reinsured. Income from the investment of the amount of such reserve shall be the unrestricted property of the title insurance company.


Section 715. Amount of Unearned Premium Reserve; Release Thereof.--(a) The unearned premium reserve of every title insurance company shall consist of:

(1) The amount of the unearned premium reserve held as of the effective date of this amendment, pursuant to or under permission granted by any prior act of Assembly; and

(2) The amount of all additions required to be made to such reserve by this section, less the withdrawals therefrom as permitted by this section.

(b) Except as otherwise provided in this subsection, every title insurance company shall add to its unearned premium reserve, in respect to each policy or contract or reinsurance agreement issued by it, a sum of money out of the fees due or received for such title insurance made by it, a sum equal to one dollar ($1) for each such policy or contract or agreement, plus ten cents (10¢) for each one thousand dollars ($1000) face amount of net retained liability, and shall each year separately report the amounts so set aside in respect to policies, contracts or agreements written in such year. If substantially the entire outstanding liability of any such title insurance company shall be reinsured, the unearned premium reserve of the reinsurer shall be equal in amount to the reserve of the ceding title insurance company in respect to such outstanding liability so reinsured.

(c) The amounts set aside as additions to the unearned premium reserve shall be deducted in determining net profits of any title insurance company.

(d) For the purposes of determining the amounts of the unearned premium reserve that may be withdrawn, and the interest of the policyholders therein under section 717 of this act, all policies, contracts or reinsurance agreements of title insurance shall be considered as dated on July 1 in the year of issue.

(e) Additions to the unearned premium reserve which shall have been held for a period of twenty years shall be released, shall no longer constitute a part of the unearned premium reserve, shall constitute a part of net profit for the year in which the release is made and may be used for any corporate purposes, including the payment of dividends.

(f) Additions to the unearned premium reserve made since the establishment of the unearned premium reserve by sections 690 to 694 shall continue to be released in the manner prescribed in subsection (e) of this section.

(g) That part of the unearned premium reserve created by sections 690 to 694, consisting of the aggregation of the reinsurance reserve fund, title reserve fund and title reserve, held as of February 1, 1956, shall continue to be released as provided in subsection (e) of this section: Provided, That the
aggregated reserve created by those sections shall continue to
be presumed to have been established out of income in twenty
equal annual additions over the twenty years preceding February
1, 1956, whether or not such title insurance company had been
in existence for that period.

Section 716. Investment and Maintenance of the Unearned
Premium Reserve.--The amount of the unearned premium reserve
shall be invested by each such title insurance company according
to the investment schedule provided in section 734 of this act. If
by reason of depreciation in the market value of investments
or other cause, the amount of the assets eligible for investment
of the unearned premium reserve should on any date be less than
the amount required to be maintained by law in such reserve,
and the deficiency shall not be promptly cured, such title
insurance company shall forthwith give written notice thereof
to the Insurance Commissioner and shall make no further policies
or contracts or reinsurance agreements of title insurance until
the amounts of such eligible investments shall have been
restored and until it shall have received written approval from
the Insurance Commissioner authorizing it to again issue such
policies or contracts or agreements.

Section 717. Use of the Unearned Premium Reserve.--(a) If
a title insurance company becomes insolvent, or is in the
process of liquidation or dissolution, or in the possession of
the Insurance Commissioner:
(1) Such amount of the assets of such title insurance
company equal to the unearned premium reserve as is necessary,
shall be used, with the written approval of the commissioner,
to pay for reinsurance of the outstanding liability of such
title insurance company upon all in-force policies or contracts
or reinsurance agreements of title insurance, as to which claims
for losses by the holders are not then pending, the balance,
if any, of the unearned premium reserve fund then to be
transferred to the general assets of the title insurance
company;
(2) The assets other than the unearned premium reserve shall
be available to pay claims for losses sustained by holders of
policies then pending or arising up to the time reinsurance is
affected. In the event that claims for losses are in excess of
such assets of the title insurance company, claims shall be
paid out of the assets attributable to the unearned premium
reserve.
(b) In the event that reinsurance is unavailable, the
unearned premium reserve and assets constituting minimum
capital, or so much as remains thereof after outstanding claims
have been paid, shall constitute a trust fund to be held by the
commissioner for twenty years, out of which claims of
policyholders shall be paid as they arise. The balance, if any,
of such fund shall, at expiration of twenty years, revert to
the general assets of the title insurance company, after
reasonable charges for administration of the fund have been
charged against the balance by the commissioner.
(c) The commissioner shall also have the authority to enter
into a contract with one or more title insurance companies to
reinsure all the obligations under outstanding policies of such
title insurance company in accordance with their terms,
covenants and conditions, the cost of said reinsurance to be
paid out of the assets of such title insurance company.
Section 718. Reserve for Unpaid Losses and Loss Expense.--(a) Each title insurance company shall at all times establish and maintain, in addition to other reserves, a reserve against unpaid losses, and against loss expense, and shall calculate such reserves by making a careful estimate in each case of the loss and loss expense likely to be incurred, by reason of every claim presented or that may be presented, pursuant to notice from or on behalf of the insured, of a title defect in or lien or adverse claim against the title insured, that may result in a loss or cause expense to be incurred for the proper disposition of the claim. The sums of the items so estimated shall be the total amounts of the reserves against unpaid losses and loss expenses of such title insurance company.

(b) The amounts so estimated shall from time to time be revised as circumstances warrant.

(c) The amounts set aside in such reserves in any year shall be deducted in determining the net profits for such year of any title insurance company.


Section 719. Primary Retained Liability.--(a) No title insurance company shall issue a policy of title insurance for a single transaction, the net primary retained liability under which shall exceed an amount which is equal to its assets, not including agency and escrow funds, less an amount equal to the sum of the minimum capital required by this article for a title insurance company, unearned premium reserve and the value of title plant, but nothing herein contained shall prevent any one or more of such title insurance companies from assuming the liability on a single policy jointly with another such title insurance company or title insurance companies in excess of this amount: Provided, That the total amount of such insurance shall not exceed the aggregate maximum net primary retentions of all title insurance companies liable under such insurance; and provided none of the title insurance companies exceeds the limit of its net primary retention for a single transaction.

(b) No title insurance company shall issue a policy of title insurance for a single transaction under which its primary liability as co-insurer shall exceed the limit of net primary retention prescribed in subsection (a) of this section.

(c) No title insurance company shall issue a policy of title insurance for a single transaction under which its secondary liability as reinsurer shall exceed the limit of net primary retention prescribed in subsection (a) of this section: Provided, That if the ceding company or companies retain primary liability at least equal to ten percent of the total amount at risk, a title insurance company may issue a policy of reinsurance for a single transaction under which its secondary liability exceeds the limit of net primary retention prescribed in subsection (a): Provided, That the total amount of its secondary liability for a single transaction shall not exceed an amount which is equal to its assets, not including agency or escrow funds, less an amount equal to the sum of the unearned premium reserve and the value of title plant. Nothing herein contained shall prevent any one or more title insurance companies from assuming the liability on a single policy jointly with another title insurance company or other title insurance companies in excess of this amount: Provided, That the total amount of such insurance shall not exceed the aggregate maximum net retentions of all such title insurance companies liable under such insurance; and provided none of the title insurance companies exceeds the limit of its net retention for a single transaction.
Section 720. Power to Reinsure.--Any title insurance company authorized to insure titles to real estate in this Commonwealth, may reinsure all or any part of its liability under one or more of its policy contracts with any title insurance company authorized to insure titles to real estate in this Commonwealth or a title insurance company authorized to insure titles to real estate in any of the United States, if such reinsuring company is, or reinsuring companies are, and remains of the same standard of solvency and complies with all other requirements fixed by the laws of this Commonwealth for title insurance companies authorized to insure titles to real estate within this Commonwealth. Any domestic title insurance company or foreign title insurance company authorized to transact business in this Commonwealth shall pay to this Commonwealth taxes required on all business taxable within this Commonwealth and reinsured, as provided in this section, with any foreign company not authorized to do business within this Commonwealth.

Section 721. Special Reinsurance.--In the event that the risk of a single transaction involving a parcel of real estate situated within this Commonwealth exceeds the total net retention, both primary and secondary, permitted by this article for all title insurance companies authorized to transact business within this Commonwealth, and the total reinsurance available from companies authorized to reinsure risks by section 720 of this act reinsurance may be obtained from companies not authorized to reinsure risks within this Commonwealth with the prior approval in writing of the commissioner.

Section 722. Licensure.--Any title insurance company organized under the laws of another State or foreign government shall be licensed to transact a title insurance business within this Commonwealth only if such company is and remains of the same standard of solvency and complies with other requirements fixed by the laws of this Commonwealth for title insurance companies organized and authorized to transact the business of title insurance pursuant to the laws of this Commonwealth. No such company shall be licensed to transact any business within the Commonwealth until it complies with the requisites for doing business as provided in section 301.

Section 723. Foreign Insurers; Resident Agent Required.--(723 repealed Dec. 21, 1995, P.L.714, No.79)

Section 724. Agents; Defined.--(a) A title insurance agent means an authorized person, firm, association, corporation, partnership or other legal entity, other than a bona fide employe of the title insurer, who on behalf of the title insurer performs the following acts, in conjunction with the issuance of a title insurance report or policy:

(1) determines insurability and issues title insurance reports or policies, or both, based upon the performance or review of a search, or an abstract of title; and
(2) performs one or more of the following functions:
   (i) collects or disburses premiums, escrow or security deposits or other funds;
   (ii) handles escrow, settlements or closings;
   (iii) solicits or negotiates title insurance business; or
   (iv) records closing documents.

The word "agent" shall not include approved attorneys, nor shall it include officers and salaried employees of any title insurance company authorized to do a title insurance business

Section 724.1. Additional Requirements.--A title insurance agent must hold a valid certificate of qualification issued by the Insurance Department and must perform the acts listed in section 724(a) under a written contract with a licensed title insurance company.

(724.1 added Dec. 21, 1995, P.L.714, No.79)

Section 724.2. Financial Responsibility.--Agents shall assume financial responsibility for all of the acts which the agent was appointed to perform by the title insurance company.

(724.2 added Dec. 21, 1995, P.L.714, No.79)

Section 725. Agents; Names to be Certified to Commissioner.--Every title insurance company authorized to transact business within this Commonwealth shall, from time to time, certify to the commissioner the names of all agents appointed by it in this Commonwealth.


Section 726. Agents; To be Certified and Appointed.--(a) Agents shall make application for a certificate of qualification with the Insurance Department for authority to act as a title insurance agent in the manner provided for in section 603 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921." Upon certification, an agent may be appointed by a title insurer with notice of such appointment to the Insurance Department in the manner provided for in section 605 of "The Insurance Department Act of 1921."

(b) Certificates of qualification for agents shall expire biennially based on the date of original issue. Certificates of qualification shall be renewed in accordance with procedures and schedules set forth under section 601 of "The Insurance Department Act of 1921," and any regulations promulgated thereunder.

(c) In addition to the requirements set forth in subsection (a), all agents for a title insurance company shall:

1. pass an examination required by the Insurance Department demonstrating reasonable familiarity with applicable insurance laws and the business of title insurance in general; and
2. satisfy the continuing education requirements for agents and brokers under 31 Pa. Code Ch. 39 (relating to continuing education for insurance agents and brokers), with the following exceptions:
   i. Title insurance agents will not be subject to the forty-eight credit-hour requirement under 31 Pa. Code § 39.8(b)(2) (relating to credit hours), but in lieu of forty-eight credit hours, will be required to complete twenty-four credit hours for each licensing period.
   ii. Title insurance agents who are attorneys and by virtue of satisfying their continuing legal education (CLE) requirement need only to complete at least three credit hours of courses of title insurance content approved by the Insurance Department.

(726 amended Dec. 21, 1995, P.L.714, No.79)

Section 726.1. Other Requirements.--Agents for a title insurance company shall be required to:

1. Obtain errors and omissions insurance in an amount acceptable to the insurer appointing the agent, but in no event in an amount less than two hundred fifty thousand dollars ($250,000) per claim and an aggregate limit of five hundred thousand dollars ($500,000) with a deductible no greater than twenty-five thousand dollars ($25,000). A title insurer shall
not provide the insurance directly or indirectly on behalf of a title insurance agent. In the event errors and omissions insurance is unavailable generally, the Insurance Department shall promulgate rules for alternative methods to comply with this paragraph.

(2) Obtain a blanket fidelity bond covering all agency employes in an amount acceptable to the title insurance company appointing the agent, but in no event in an amount less than one hundred fifty thousand dollars ($150,000) and with a deductible not larger than fifteen percent of the bond penalty. The bond shall be executed by an insurance company authorized to do business in this Commonwealth. When the agency has no employes except the owners, partners or stockholders, the agency, with sufficient documentation, may apply to the Insurance Department for a waiver of this fidelity bond requirement. The required bond premium shall be paid by the title insurance agent, and a title insurer shall not provide the bond directly or indirectly on behalf of a title insurance agent. Except for the inception of this requirement, the bond term must conform to the term of the agent's certification, and documentation of coverage must be furnished to the Insurance Department at the time of certification renewal. In the event of cancellation by the insurance company, the insurer must give the Commonwealth thirty (30) days' written notice before the cancellation will be deemed effective.

(3) Post a surety bond in the form prescribed by the Insurance Department of not less than one hundred thousand dollars ($100,000). The bond shall be executed by an insurance company authorized to do business in this Commonwealth. For purposes of this section, an agency is defined as an individual person, partnership, corporation or other legal entity that conducts the business of title insurance on behalf of a title insurer. The bond shall secure performance by the agent of his fiduciary duties and responsibilities. The bond will remain in full force and effect until cancelled. In the event of cancellations by the surety, thirty (30) days' notice must be given to the Insurance Department before the cancellation will be deemed effective. The premium required for the bond shall be paid by the title insurance agent, and a title insurance company shall not provide the bond directly or indirectly on behalf of a title insurance agent. The aggregate liability of the surety for any and all breaches of the conditions of the bond shall in no event exceed the penal sum of the bond. Title insurers are exempt from the requirement of obtaining a surety bond.

(4) Render accounts to the title insurer detailing all transactions and remit all funds and policies due under the contract to the title insurer on a specified basis.

(5) Collect and hold in a fiduciary capacity for the account of a title insurer all funds due the title insurer in a bank or other financial institution insured by an agency of the Federal Government. Each account shall be used for all payments on behalf of the title insurer with whom a title agency contract exists.

(6) Keep separate records of business written for each title insurer. The title insurer shall have access and a right to copy all files, accounts and records related to its business in a form acceptable to the title insurer, and the Insurance Commissioner shall have access to all files, books, bank accounts and records of the title insurance agent in a form usable to the Insurance Commissioner.

(726.1 added Dec. 21, 1995, P.L.714, No.79)
Section 727. Agents; Books, Records, etc.--Every agent of a title insurance company shall keep his, her or its books, records, accounts and vouchers pertaining to the business of title insurance, in such manner that the commissioner or his authorized representatives may readily ascertain from time to time, whether or not the agent has complied with all of the applicable provisions of this act. Failure to comply with this section shall be a ground for revocation of the agent's license. (727 added Aug. 14, 1963, P.L.922, No.439)

Section 728. Agents; Replies to Inquiries by Commissioner.--Every agent of a title insurance company shall reply, in writing, promptly to any inquiry of the commissioner relative to the agent's conduct of the business of title insurance, and failure to reply shall be a ground for revocation of the agent's license. (728 added Aug. 14, 1963, P.L.922, No.439)

Section 729. Agents; Certain Names Prohibited.--After the effective date of this amendment no agent for a title insurance company shall adopt a firm name containing the words "title," "title company," "title insurance company," "guaranty," "guarantee," "guaranty company," or "guarantee company" or similar combination thereof. (729 added Aug. 14, 1963, P.L.922, No.439)

Section 730. Commissions; Right to Pay.--(730 repealed Dec. 21, 1995, P.L.714, No.79)

Section 731. Commissions; Other Considerations Prohibited.--(a) No title insurance company or agent or approved attorney of a title insurance company shall pay, give or award to an applicant for title insurance any compensation, consideration, benefit or remuneration, directly or indirectly.

(b) The following activities, whether performed directly or indirectly, are deemed per se inducements for the placement or referral of title insurance business by any person and are unlawful:

(1) Paying or offering to pay, furnishing or offering to furnish, or providing or offering to provide assistance with the business expenses of any person, including, but not limited to, rent, employe salaries, furniture, copiers, facsimile machines, automobiles, telephone services or equipment or computers.

(2) Providing or offering to provide any form of consideration intended for the benefit of any person, including cash, below market rate loans, automobile charges, merchandise or merchandise credits.

(3) Placing or offering to place compensating balances on behalf of any person.

(4) Advancing or paying or offering to advance or pay money on behalf of any person into escrow to facilitate a closing, except a sum which represents the proceeds of a loan made in the ordinary course of business.

(5) Disbursing or offering to disburse on behalf of any person escrow funds held by a title insurance company or title insurance agent before the conditions of the escrow applicable to the disbursement have been met.

(6) Furnishing or offering to furnish all or any part of the time or productive effort of any employe of the title insurance company or title insurance agent to any person for any service unrelated to the title business.

(c) Reasonable expenditures for food, beverages, entertainment, educational programs and promotional items constituting ordinary business expenses are deemed not to constitute an inducement for the placement or referral of title
business if the expenditures are correctly reported and properly substantiated as an ordinary and necessary business expense under provisions of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.) and regulations issued thereunder and the expenditures do not violate any other law.

(d) The provision or payment of any form of consideration as an inducement for the placement or referral of title business not specifically set forth in this section shall not be presumed lawful merely because it is not specifically prohibited.

(e) The Insurance Commissioner may determine compliance and enforce the provisions of this section by written order, regulation or written consent.

(731 amended Dec. 21, 1995, P.L.714, No.79)

Section 732. Capital.--The capital of a title insurance company shall be invested in the following classes of investment:

(1) Government Obligations. Bonds, notes or obligations issued, assumed or guaranteed by the United States or the Dominion of Canada, or by any state, district or territory of the United States.

(2) Governmental Subdivision or Public Instrumentality Obligations. Valid and legally authorized bonds, notes or obligations issued, assumed or guaranteed by:

(i) any city, town, county, borough, township, municipality, school district, poor district, water, sewer, drainage, road or other governmental district or division located in the United States or any state, district or territory thereof; or by

(ii) any public instrumentality other than a municipal authority of one or more of the foregoing, if, by statutory or other legal requirements applicable thereto, such bonds or other evidences of indebtedness of such instrumentality are payable, as to principal and interest, from taxes levied or by law required to be levied, upon all taxable property or all taxable income within the jurisdiction of the governmental unit or units of which it is an instrumentality, or from revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment;

(iii) any municipal authority issued pursuant to the laws of the Commonwealth relating to the creation or operation of municipal authorities, if the obligations are not in default as to principal or interest and if the project for which the obligations were issued is under lease to a school district or school districts or if the obligations are not in default as to principal or interest and if the project for which the obligations were issued is under lease to a municipality or municipalities or subject to a service contract with a municipality or municipalities, pursuant to which the municipal authority will receive lease rentals or service charges available for fixed charges on the obligations, which will average not less than one and one-fifth times the average annual fixed charges of such obligations over the life thereof, or if the obligations are not in default as to principal or interest and if for the period of five fiscal years next preceding the date of acquisition, the income of such authority available for fixed charges has averaged not less than one and one-fifth times its average annual fixed charges of such obligations over the life of such obligations. As used in this subclause the term "income available for fixed charges" shall mean income after deducting operating and maintenance expenses, and, unless the obligations are payable in serial, annual maturities, or are supported by annual sinking fund payments, depreciation, but excluding extraordinary nonrecurring items of income or
expenses; and the term "fixed charges" shall include principal, both maturity and sinking fund, and interest on bonded debt. In computing such income available for fixed charges for the purposes of this section, the income so available of any corporation acquired by any municipal authority may be included, such income to be calculated as though such corporation had been operated by a municipal authority and an equivalent amount of bonded debt were outstanding. The eligibility for investment purposes of obligations of each project of a municipal authority shall be separately considered hereunder.

(3) Public Utility Obligations. Bonds, notes or obligations issued, assumed or guaranteed by any solvent public utility corporation or public utility business trust, incorporated or existing under the laws of the United States or of any state, district or territory thereof.

(4) Other Corporate Obligations. Bonds, notes or obligations issued, assumed or guaranteed by any other corporation, including railroads, or business trust, incorporated or existing under the laws of the United States or of any state, district or territory thereof, whose income available for fixed charges for the period of five fiscal years next preceding the date of investment shall have averaged not less than one and one-half times its average annual fixed charges applicable to such period. As used in this clause, the term "income available for fixed charges" shall mean income, after deducting operating and maintenance expenses, depreciation and depletion, and taxes other than Federal or State income taxes, but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of the corporation or business trust, and the term "fixed charges" shall include interest on funded and unfunded debt and amortization of debt discount and expense. If income is determined in reliance upon consolidated income statements of parent and subsidiary corporations or business trusts, such income shall be determined after provision for Federal and State income taxes of subsidiaries, and after proper allowance for minority stock interest, if any, and the required coverage of fixed charges, shall be computed on a basis including fixed charges and preferred dividends of subsidiaries, other than those payable by subsidiaries to the parent corporation or business trust, or to any other such subsidiaries.

In applying an income test under this clause to any issuing, assuming or guaranteeing corporation or business trust, whether or not in legal existence during the whole of the five-year period next preceding the date of investment, which has at any time or times after the beginning of such period acquired the assets or the outstanding shares of capital stock of any other corporation or business trust by purchase, merger, consolidation or otherwise, substantially as an entirety, or has been reorganized pursuant to the bankruptcy law, the income of such other predecessor or constituent corporation or business trust or of the corporation or business trust so reorganized, available for interest and dividends for such portion of such period as shall have preceded acquisition or reorganization may be included in the income of such issuing, assuming or guaranteeing corporation or business trust for such portion of such period as may be determined in accordance with adjusted or pro forma consolidated income statements covering such portion of such period, and giving effect to all stock or shares outstanding and all fixed charges existing immediately after acquisition or reorganization.

(5) Trustees', Receivers' or Equipment Trust Obligations.
(i) Certificates, notes or obligations issued by trustees or receivers of any corporation or business trust created or existing under the laws of the United States or of any state, district or territory thereof which or the assets of which, are being administered under the direction of any court having jurisdiction, if such obligation is adequately secured as to principal and interest.

(ii) Equipment trust obligations or certificates, which are adequately secured, or other adequately secured instruments, evidencing an interest in transportation equipment, wholly or in part within the United States, and a right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of such transportation equipment.

(6) Acceptances and Bills of Exchange. Bank and bankers' acceptances, and other bills of exchange of the kind and maturities made eligible pursuant to law for purchase in the open market by Federal Reserve Banks.

(7) Real Estate Loans. Ground rents and bonds, notes or other evidences of indebtedness, secured by mortgages or trust deeds upon unencumbered real property located in any state, district or territory of the United States, and in investments in the equity of the seller under contracts for deeds covering the entire balance due on bona fide sales of such real property: Provided, That a loan guaranteed or insured in full by the Administrator of Veterans' Affairs pursuant to the provisions of the Federal Servicemen's Readjustment Act of 1944, as heretofore or hereafter amended, may be subject to a prior encumbrance. Real property shall not be considered to be encumbered within the meaning of this clause by reason of the existence of instruments reserving mineral, oil, water or timber rights, rights of way, sewer rights, rights in walls or driveways, by reason of liens inferior to the lien securing the loan of the title insurance company, or liens for taxes or assessments not yet delinquent, or by reason of building restrictions or other restrictive covenants or by reason of any lease under which rents or profits are reserved to the owner, if, in any event, the security for such loan is a first lien upon such real property, and if there is no condition or right of re-entry or forfeiture under which such lien can be cut off, subordinated or otherwise disturbed. No mortgage or trust deed, loan or investment in a seller's equity under a contract for deed made or acquired by the title insurance company on any one property shall at the date of investment exceed two-thirds of the value of the real property securing the loan, or subject to such contract: Provided, That such limitation in respect to value shall not apply to a loan which is:

(i) insured by, or for which a commitment to insure has been made by, the Federal Housing Administrator or Commissioner, pursuant to the provisions of the Federal National Housing Act, as heretofore or hereafter amended;

(ii) guaranteed by the Administrator of Veterans' Affairs pursuant to the provisions of the Federal Servicemen's Readjustment Act of 1944, as heretofore or hereafter amended, except, that if only a portion of a loan is so guaranteed, such limitation shall apply to the portion not so guaranteed;

(iii) insured by the administrator pursuant to the provisions of the Federal Servicemen's Readjustment Act of 1944, as heretofore or hereafter amended;

(iv) upon real estate under lease to a corporation or business trust, incorporated or existing under the laws of the United States or any state, district or territory thereof, whose
income available for fixed charges for the period of five fiscal years next preceding the date of investment, shall have averaged not less than one and one-half times its average annual fixed charges applicable to such period, if there is pledged and assigned, as additional security for the loan, and for application thereon, sufficient of the rentals payable under the lease to provide for repayment of the loan within the unexpired term of the lease;

(v) upon such terms that the principal thereof will be amortized by repayments of principal at least once in each year in amounts sufficient to repay the loan within a period of not more than thirty years, and such loan is upon improved real estate, and at the date of investment does not exceed three-fourths of the value of the real estate securing the loan.

(8) Purchase Money Securities. Purchase money mortgages or like securities received by it upon the sale or exchange of real property, acquired pursuant to clause (20) of this section.

(9) Federal Housing Administrators Debentures. Debentures issued by the Federal Housing Administrator or Commissioner in settlement of claims pursuant to the Federal National Housing Act, as heretofore or hereafter amended.

(10) National Mortgage Association Securities. Securities of national mortgage associations or similar national mortgage credit institutions organized under the Federal National Housing Act, as heretofore or hereafter amended.

(11) Federal Land Bank, Federal Intermediate Credit Bank and Bank for Cooperatives Securities. Bonds, debentures and other obligations of Federal Land Banks or Federal Intermediate Credit Banks issued pursuant to the Federal Farm Loan Act, as heretofore or hereafter amended, or of Banks for Cooperatives issued pursuant to the Farm Credit Act of 1933, as heretofore or hereafter amended.

(12) Loans upon Leaseholds. Loans upon leasehold estates or unencumbered real estate located in any state, district or territory of the United States: Provided, That no such loan shall exceed two-thirds of the value of the leasehold at the date of investment, unless:

(i) such loan is guaranteed or insured by, or for which a commitment to guarantee or insure such loan has been made by, the Federal Housing Administrator or Commissioner, pursuant to the provisions of the Federal National Housing Act, as heretofore or hereafter amended;

(ii) such leasehold is of improved real estate and such loan provides for amortization by repayments of principal at least once in each year in amounts sufficient to repay the loan within a period of four-fifths of the unexpired term of the leasehold, but within a period of not more than thirty years, and does not exceed three-fourths of the value of the leasehold at the date of investment;

(iii) such real estate is under lease to a corporation or business trust, incorporated or existing under the laws of the United States or any state, district or territory thereof, whose income available for fixed charges for the period of five fiscal years next preceding the date of investment shall have averaged not less than one and one-half times its average annual fixed charges applicable to such period, if there is pledged and assigned as additional security for the loan and for application thereon sufficient of the rentals payable under such lease to provide for repayment of the loan within the unexpired term of the lease.

Provided further, That the terms of any such loan shall require repayments of principal at least once in each year in
amounts sufficient to repay the loan within the term of the leasehold, unexpired at the date of investment, unless a shorter period is required under subclause (ii).

(13) Savings and Loan Shares. Shares of any Federal savings and loan association, or of any building and loan or savings and loan association, to the extent that the withdrawal or repurchase value of such shares is insured by the Federal Savings and Loan Insurance Corporation under the Federal National Housing Act, as heretofore or hereafter amended.

(14) Federal Savings and Loan Insurance Corporation Obligations. Bonds, notes or obligations issued, assumed or guaranteed by the Federal Savings and Loan Insurance Corporation, under the provisions of the Federal National Housing Act, as heretofore or hereafter amended.

(15) Federal Home Loan Bank Obligations. Bonds, notes or obligations issued, assumed or guaranteed by the Federal Home Loan Bank, or issued, assumed or guaranteed by the Federal Home Loan Bank Board under the provisions of the Federal Home Loan Bank Act, as heretofore or hereafter amended.

(16) International Bank Obligations. Bonds, notes or obligations issued, assumed or guaranteed by the International Bank for Reconstruction and Development.

(17) Business Development Credit Corporation Shares. Shares of State and regional business development credit corporations formed under the laws of this Commonwealth.

(18) Pennsylvania Housing Agency Bonds and Notes. Bonds and notes of the Pennsylvania Housing Agency created by the "Housing Agency Law."

(19) Inter-American Development Bank Obligations. Bonds, notes or obligations issued, assumed or guaranteed by the Inter-American Development Bank.

(20) Real Estate; Right to Acquire. It shall be lawful for any title insurance company organized under the laws of this Commonwealth to purchase, receive, hold and convey real estate or any interest therein:

(i) required for its convenient accommodation in the transaction of its business with reasonable regard to future needs;

(ii) acquired in connection with a claim under a policy of title insurance;

(iii) acquired in satisfaction or on account of loans, mortgages, liens, judgments or decrees, previously owing to it in the course of its business;

(iv) acquired in part payment of the consideration of the sale of real property owned by it if the transaction shall result in a net reduction in the company's investment in real estate;

(v) reasonably necessary for the purpose of maintaining or enhancing the sale value of real property previously acquired or held by it under subclauses (i), (ii), (iii) or (iv) of this clause: Provided, however, That no title insurance company shall continue to hold any real estate acquired by it under subclauses (ii), (iii) or (iv) for more than five years from the date of acquisition thereof, unless it shall obtain the written approval of the commissioner to hold such real estate for a longer period of time.

(21) Title Plant. Provided it shall at all times keep at least two hundred fifty thousand dollars ($250,000), invested in the classes of securities authorized for the investment of capital other than title plant and real estate, a title insurance company may invest in a title plant. The title plant shall be considered an admitted asset at the fair value thereof.
In determining the fair value of a title plant, no value shall be attributed to furniture and fixtures, and the real estate in which the title plant is housed shall be carried as real estate. The value of title abstracts, title briefs, copies of conveyances or other documents, indices and other records comprising the title plant, shall be determined by considering the expenses incurred in obtaining them, the age thereof, the cost of replacements less depreciation, and all other relevant factors. Once the value of a title plant shall have been determined hereunder, such value may be increased only by the acquisition of another title plant by purchase, consolidation or merger; in no event shall the value of the title plant be increased by additions made thereto as part of the normal course of abstracting and insuring titles to real estate. Subject to the above limitations and with the approval of the commissioner, a title insurance company may enter into agreements with one or more other title insurance companies authorized to do business in this Commonwealth, whereby such companies shall participate in the ownership, management and control of a title plant to service the needs of all such companies or such companies may hold stock of a corporation owning and operating a title plant for such purposes: Provided, That each of the companies participating in the ownership, management and control of such jointly owned title plant shall keep the sum of two hundred fifty thousand dollars ($250,000) invested as above set forth.


Section 733. Surplus.--Money over and above capital, other than the unearned premium reserve, may be invested in the following classes of investments:

(1) Any of the classes of investment authorized in section 732 of this article.

(2) Corporate Stock or Shares. Stock or shares of any solvent corporation, incorporated under the laws of the United States or any state, district or territory thereof, the Commonwealth of Puerto Rico, or of the Dominion of Canada or any province thereof, including the stock of another title insurance company.

(3) Corporate Obligations. Bonds, notes or obligations issued, assumed or guaranteed by any solvent corporation or business trust, incorporated or existing under the laws of the United States or any state, district or territory thereof, the Commonwealth of Puerto Rico, or of the Dominion of Canada or any province thereof.

(4) Canadian Governmental Subdivision Obligations. Valid and legally authorized bonds, notes or obligations issued, assumed or guaranteed by any province, county, city, town, village, municipality or political subdivision of the Dominion of Canada.

(5) Other Loans or Investments. Loans or investments not qualifying or permitted under the preceding subsections of this section, to an amount not exceeding five per cent of such company's admitted assets.


Section 734. Unearned Premium Reserve.--The unearned premium reserve of a title insurance company shall be invested in the same classes of investments, other than title plant and real estate, authorized for the investment of capital, except that one-fourth of such reserve may be invested in preferred or guaranteed stocks or shares of any solvent corporation or business trust, incorporated or existing under the laws of the United States or of any state, district or territory thereof,
whose net earnings available for its fixed charges, during either of the two years preceding the date of such investment have been, and during each of the five years preceding such date, have averaged not less than one and one-half times the sum of its average annual fixed charges, as referred to in clause (4) of section 732, if any, and its average annual preferred dividend requirements. For the purposes of this section, such computation shall refer to the fiscal year immediately preceding the date of acquisition of an investment by the insurer, and the term "preferred dividend requirement," shall include cumulative or noncumulative dividends, whether paid, earned or not.


Section 735. Other Reserves.--Reserves other than the unearned premium reserve may be invested in any of the classes of investments authorized in clauses (1), (2), (3), (4) and (5) of section 733 of this article.


Section 736. Investments Acquired before Effective Date.--Any investment of a title insurance company lawfully acquired before the effective date of this amendment and which but for this section would be considered ineligible as an investment on such effective date, shall be disposed of within three years from such effective date. The commissioner, upon application and proof that forced sale of any such investment would be contrary to the best interests of the title insurance company and its policyholders, may extend the period for sale or disposal of such investment for a further reasonable time, in no event to exceed three years.


Section 737. Rate Filing.--(a) Every title insurance company shall file with the commissioner every manual of classifications, rules, plans, and schedules of fees and every modification of any of the foregoing relating to the rates which it proposes to use. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated. ((a) amended Dec. 21, 1995, P.L.714, No.79)

(b) A title insurance company may satisfy its obligations to make such findings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings, and by authorizing the commissioner to accept such filings on its behalf.

(c) The Commissioner shall make such review of the filings as may be necessary to carry out the provisions of this article.

(d) Subject to the provisions of subsections (f) and (g) of this section, each filing shall be on file for a period of thirty days before it becomes effective. The commissioner may, upon written notice given within such period to the person making the filing, extend such waiting period for an additional period, not to exceed thirty days to enable him to complete the review of the filing. Further extensions of such waiting period may also be made with the consent of the title insurance company or rating organization making the filing. Upon written application by the title insurance company or rating organization making the filing, the commissioner may authorize a filing or any part thereof which he has reviewed, to become effective before the expiration of the waiting period or any extension thereof.

(e) Except in the case of rates filed under subsections (f) and (g) of this section, a filing which has become effective shall be deemed to meet the requirements of this article.
(f) When the commissioner finds that any rate for a particular kind or class of risk cannot practicably be filed before it is used, or any contract or kind of title insurance, by reason of rarity or peculiar circumstances, does not lend itself to advance determination and filing of rates, he may, under such rules and regulations as he may prescribe, permit such rates to be used without a previous filing and waiting period.

(g) Upon the written consent of the insured stating his reasons therefor, filed with the commissioner, a rate in excess of that provided by a filing which might otherwise be deemed applicable may be used on any specific risk. The rate shall become effective when such consent is filed.

(h) Beginning ninety days after the effective date of this amendment, no title insurance company or agent of a title insurance company shall charge any fee for any policy or contract of title insurance except in accordance with filings or rates which are in effect for said title insurance company or such agent of a title insurance company as provided in this article, or in accordance with subsections (f) and (g) of this section.


Section 738. Justification for Rates.--A rate filing shall be accompanied by a statement of the title insurance company or rating organization making the filing, setting forth the basis upon which the rate was fixed and the fees are to be computed. Any filing may be justified by:

(1) The experience or judgment of the title insurance company or rating organization making the filing; or
(2) The experience of other title insurance companies or rating organizations; or
(3) Any other factors which the title insurance company or rating organization deems relevant.

The statement and justification shall be open to public inspection after the rate to which it applies becomes effective.


Section 739. Making of Rates.--(a) In making rates, due consideration shall be given to past and prospective loss experience, to exposure to loss, to underwriting practice and judgment, to the extent appropriate, to past and prospective expenses, including commissions paid to agents, the expenses incurred by title insurance companies, to a reasonable margin for profit and contingencies, and to all other relevant factors both within and outside of this Commonwealth. ((a) amended Dec. 21, 1995, P.L.714, No.79)

(b) Rates shall not be inadequate or unfairly discriminatory, nor shall rates be excessive; that is, such as to permit title insurance companies to earn a greater profit, after payment of all taxes upon all income, than is necessary to enable them to earn over the years sufficient amounts to pay their actual expenses and losses arising in the conduct of their title insurance business, including commissions paid and the actual costs of maintaining a title plant, plus a reasonable profit.

(c) In ascertaining the estimated future earnings of title insurance companies, the commissioner shall utilize a properly weighted cross section of title insurance companies operating in this Commonwealth representative of the average of normally efficiently operated title insurance companies including on a weighted basis, both title insurance companies having their own title plants, and those not operating upon the title plant system. In ascertaining what is a reasonable profit after
payment of all taxes on such income, the commissioner shall
give due consideration to the following matters:
(1) The average rates of profit after payment of taxes on
all income earned by other industry generally;
(2) The desirability of stability of rate structure;
(3) The necessity of insuring through growth in assets in
times of high business activity, the financial solvency of title
insurance companies in times of economic depression; and
(4) The necessity for earning sufficient dividends on the
stock of title insurance companies to induce capital to be
invested in title insurance companies.
(d) The systems of expense provisions and the amount of
expense charged against each class of contract or policy may
vary between title insurance companies. Rates may, in the
discretion of any title insurance company, be less than the
cost of performing the work in the case of smaller insurances,
and the excess may be charged against the larger insurances
without rendering the rates unfairly discriminatory.
Section 739.1. Conditions.--A title insurer or title agent
may engage in the escrow, settlement or closing business or any
combination of such businesses and operate as an escrow,
settlement or closing agent, in connection with the issuance
of a title insurance policy, provided that:
(1) Funds deposited in connection with any escrow,
settlement, closing or title indemnification shall be deposited
in a separate fiduciary trust account or accounts in a bank or
other financial institution insured by an agency of the Federal
Government. Such funds shall be the property of the person or
persons entitled thereto in accordance with the provision of
the escrow, settlement, closing or title indemnification and
shall be segregated by escrow, settlement, closing or title
indemnification in the records of the title insurer or title
agent. Such funds shall not be subject to any debts of the title
insurer or title agent and shall be used only in accordance
with the terms of the individual escrow, settlement, closing
or title indemnification under which the funds were accepted.
(2) The title insurer or title agent shall maintain separate
records of all receipts and disbursements of escrow, settlement,
closing or title indemnification funds.
(3) The title insurer or title agent shall comply with any
rules or regulations promulgated by the Insurance Commissioner
pertaining to escrow, settlement, closing or title
indemnification transactions.
(739.1 added Dec. 21, 1995, P.L.714, No.79)
Section 739.2. Division of Fees.--Nothing in this act shall
be construed as prohibiting the division of fees between or
among a title insurer and its title agent, two or more title
insurers and their title agent, two or more title insurers, one
or more title insurers and one or more title agents, or two or
more title agents, provided such division of fees does not
constitute an unlawful rebate or inducement under the provisions
of this act.
(739.2 added Dec. 21, 1995, P.L.714, No.79)
Section 740. Disapproval of Filings.--(a) Upon the review
at any time by the commissioner of a filing, he shall, before
issuing an order of disapproval, hold a hearing upon not less
than ten days written notice, specifying in reasonable detail
the matters to be considered at such hearing, to every title
insurance company and rating organization which made such
filing, and if, after such hearing, he finds that such filing
or a part thereof does not meet the requirements of this
article, he shall issue an order specifying in what respects he finds that it so fails, and stating when, within a reasonable period thereafter, such filing or a part thereof shall be deemed no longer effective if the filing or a part thereof has become effective under the provisions of section 737. Provided, however, That a title insurance company or rating organization shall have the right at any time to withdraw a filing or a part thereof, subject to the provisions of section 742 in the case of a deviation filing. Copies of said order shall be sent to every such title insurance company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(b) Any person or organization aggrieved with respect to any filing which is in effect, may make written application to the commissioner for a hearing hereon: Provided, however, That the title insurance company or rating organization that made the filing shall not be authorized to proceed under this subsection. Such application shall specify in reasonable detail the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall, within thirty days after receipt of such application, hold a hearing upon not less than ten days written notice to the applicant and to every title insurance company and rating organization which made such a filing. If, after such hearing, the commissioner finds that the filing or a part thereof does not meet the requirements of this article, he shall issue an order specifying in what respects he finds that such filing or a part thereof fails to meet the requirements, stating when within a reasonable period thereafter, such filing or a part thereof shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such title insurance company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(c) No filing nor any modification thereof shall be disapproved if the rates in connection therewith meet the requirements of this article.


Section 741. Rating Organizations.--(a) A corporation, an unincorporated association, a partnership or an individual, whether located within or outside this Commonwealth, may make application to the commissioner for license as a rating organization for title insurance companies, and shall file therewith:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its by-laws, rules and regulations governing the conduct of its business;

(2) A list of its members and subscribers;

(3) The name and address of a resident of this Commonwealth upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and

(4) A statement of its qualifications as a rating organization. If the commissioner finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization, and that its constitution, articles of agreement or association or certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its
business conforms to the requirements of law, he shall issue a license authorizing the applicant to act as a rating organization for title insurance. Every such application shall be granted or denied in whole or in part by the commissioner within sixty days of the date of its filing with him. Licenses issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner or withdrawn by the licensee. The fee for said license shall be twenty-five dollars ($25). Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this subsection. Every rating organization shall notify the commissioner promptly of every change in:

(i) Its constitution, its articles of agreement or association or its certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its business;

(ii) Its list of members and subscribers; and

(iii) The name and address of the resident of this Commonwealth designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

(b) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any title insurance company not a member to be a subscriber to its rating services. Notices of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit a title insurance company as a subscriber, shall, at the request of any subscriber or any such title insurance company, be reviewed by the commissioner at a hearing held upon at least ten days written notice to such rating organization and to such subscriber or title insurance company. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an application of a title insurance company for subscribership within thirty days after it was made, the title insurance company may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the title insurance company has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the title insurance company as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

(c) Cooperation among rating organizations, or among rating organizations and title insurance companies, and concert of action among title insurance companies under the same general management and control in rate making or in other matters within the scope of this article is hereby authorized, provided the filings resulting therefrom are subject to all the provisions of this article which are applicable to filings generally. The commissioner may review such activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this article, he may issue a written order
specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this article and requiring the discontinuance of such activity or practice.


Section 742. Deviations.--Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization, except that any title insurance company which is a member of or subscriber to a rating organization may file with the commissioner a uniform percentage of decrease or increase to be applied to any or all elements of the fees produced by the rating system so filed for a class of title insurance which is found by the commissioner to be a proper rating unit for the application of such uniform decrease or increase, or to be applied to the rates for a particular area, or with respect to the amount of commissions to be paid. Such deviation filing shall specify the basis for the modification and shall be accompanied by the data or historical pattern upon which the applicant relies. A copy of the filing and data shall be sent simultaneously to such rating organization. Any such deviation filing shall be on file for a waiting period of thirty days before it becomes effective. Extension of such waiting period may be made in the same manner that such period is extended in the case of rate filings. Upon written application of the person making the filing, the commissioner may authorize a deviation filing or any part thereof to become effective before the expiration of the waiting period or any extension thereof. Deviation filings shall be subject to the provisions of section 740. Each deviation shall be effective for at least one year from the date such deviation is filed unless terminated sooner with the approval of the commissioner, or in accordance with the provisions of section 740.


Section 743. Appeal by Minority.--(a) Any member of or subscriber to a rating organization may appeal to the commissioner from any action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization, and the commissioner shall, after a hearing held upon not less than ten days written notice to the appellant and to such rating organization, issue an order approving the action or decision of such rating organization or directing it to give further consideration to such proposal and to take action or make a decision upon it within thirty days, or, if such appeal is from the action of the rating organization in rejecting a proposed addition to its filings, he may, in the event he finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order: Provided, However, if the appeal is from the action of the rating organization with regard to a rate or a proposed change in or addition to its filings relating to the character and extent of coverage, he shall approve the rate applied by the rating organization or such rate as may be suggested by the appellant, if either rate be in accordance with this article.

(b) The failure of a rating organization to take action or make a decision within thirty days after submission to it of a proposal under this section shall constitute a rejection of such proposal within the meaning of this section.
(c) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in subsection (d) of section 739 from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if he grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal, the commissioner shall apply the standards set forth in section 739.


Section 744. Information to be Furnished Insureds; Hearings and Appeals of Insureds.--(a) Every rating organization and every title insurance company which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(b) Every rating organization and every title insurance company which makes its own rates shall provide, within this Commonwealth, reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his authorized representative, on his written request to review the manner in which such rating system has been applied in connection with the insurance afforded him. If the rating organization or title insurance company fails to grant or reject such request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such rating organization or such title insurance company on such request may, within thirty days after written notice of such action, appeal to the commissioner, who, after a hearing held upon not less than ten days written notice to the appellant and to such rating organization or insurer, may affirm or reserve such action.


Section 745. Examinations of Rating Organizations.--The commissioner shall, at least once in five years, make or cause to be made an examination of such rating organization licensed under this article in this Commonwealth. The reasonable costs of any such examination shall be paid by the rating organization examined upon presentation to it of a detailed account of such costs. The officer, manager, agents and employees of such rating organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish two copies of the examination report to the organization examined and shall notify such organization that it may, within twenty days thereafter, request a hearing on said report or on any facts or recommendations therein. Before filing any such report for public inspection, the commissioner shall grant a hearing to the organization examined. The report of any such examination, when filed for public inspection, shall be admissible in evidence in any action or proceeding brought by the commissioner against the organization examined, or its officers or agents, and shall be prima facie evidence of facts stated therein. The commissioner may withhold the report of any such examination from public inspection for such time as he may deem proper. In lieu of any such examination, the commissioner may accept the report of an examination made by the insurance
supervisory official of another state pursuant to the laws of such state.


Section 746. Rate Administration; Authority and Duties of Commissioners; Rules and Regulations.-(a) The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him, which may be modified from time to time, and which shall be used thereafter by each title insurance company, in the recording and reporting of the composition of its business, its loss and countrywide expense experience and those of its title insurance underwriters in order that the experience of all title insurance companies may be made available, at least annually, in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in this article. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this Commonwealth and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating such rules and plans, the commissioner shall give due consideration to the rating systems on file with him, and in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. Such rules and plans shall not place an unreasonable burden of expense on any title insurance company. No title insurance company shall be required to record or report its expense and loss experience on a classification basis that is inconsistent with the rating system filed by it, nor shall any title insurance company be required to report its experience to any agency of which it is not a member or subscriber. The commissioner may designate one or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to title insurance companies and rating organizations.

(b) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(c) In order to further uniform administration of rate regulatory laws, the commissioner and every title insurance company and rating organization may exchange information and experience data with insurance supervisory officials, title insurance companies and rating organizations in other states, and may consult with them with respect to rate making and the application of rating systems.

(d) In addition to any powers herein before expressly enumerated in this act, the commissioner shall have full power and authority, and it shall be his duty, to enforce and carry out by regulations, orders or otherwise, all and singular the provisions of this article and the full intent thereof. The commissioner may make such reasonable rules and regulations not inconsistent with this article, as may be necessary or proper in the exercise of his powers or for the performance of his duties under this article.


Section 747. False or Misleading Information.--No person or organization shall wilfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, or any title insurance
company, which will affect the rates or fees chargeable under this article.


Section 748. Penalties.--(a) The commissioner may, if he finds that any person or organization has violated any provision of this article, impose a penalty of not more than five hundred dollars ($500) for each such violation, but if he finds such violation to be wilful, he may impose a penalty of not more than five thousand dollars ($5,000) for each such violation. Such penalties may be in addition to any other penalty provided by law. ((a) amended Dec. 21, 1995, P.L.714, No.79)

(b) The commissioner may suspend the license of any rating organization or title insurance company which fails to comply with an order of the commissioner within the time limited by such order, or any extension thereof which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or title insurance company for failure to comply with an order until the time prescribed for an appeal therefrom has expired, or, if an appeal has been taken, until such order has been affirmed. The commissioner may determine when a suspension of license shall become effective, and it shall remain in effect for the period fixed by him, unless he modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

(c) No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner, stating his findings, made after a hearing held upon not less than ten days written notice to such person or organization, specifying the alleged violation.


Section 749. Hearing Procedure and Judicial Review.--(a) Any title insurance company, rating organization or person aggrieved by any action of the commissioner, except disapproval of a filing or a part thereof, or by any rule or regulation adopted and promulgated by the commissioner, shall have the right to file a complaint with the commissioner and to have a hearing thereon before the commissioner. Pending such hearing and the decision thereon, the commissioner may suspend or postpone the effective date of his previous action, rule or regulation.

(b) All hearings provided for in this article shall be conducted, and the decision of the commissioner on the issue or filing involved shall be rendered, in accordance with the provisions of the act of June 4, 1945 (P.L.1388), known as the "Administrative Agency Law" relating to adjudication procedure.

(c) (c) repealed Apr. 28, 1978, P.L.202, No.53)


Section 750. Existing Filings and Hearings, Continued.--All title insurance manuals of classifications, rules and rates, rating plans and modifications thereof filed under any repealed act shall be deemed to have been filed under this article, and all title insurance rating organizations licensed under such repealed act shall be deemed to have been licensed under this article. All hearings and investigations pending under such repealed act shall be deemed to have been initiated under and shall be continued under this article.


Section 752. Corporate Acquisitions Other Than by Merger or Consolidation.--(752 repealed Dec. 19, 1990, P.L.834, No.198 and Feb. 17, 1994, P.L.92, No.9)

Section 753. Acquisition of Controlling Stock.--(753 repealed Feb. 17, 1994, P.L.92, No.9)

Section 754. Other Sections Applicable.--In addition to the provisions of this article, only the following provisions of the laws governing insurance companies as presently enacted and hereinafter amended, except as they are inconsistent with the provisions of this article, shall apply to the business of title insurance and to title insurance companies, which shall be considered as within the class of insurance companies regulated by such provisions solely for the limited purpose of being subject to such provisions:

(1) Sections 1, 101 to 106, 201, 202, 205 to 212, 218, 219, 221, 401, 404, 501, 502, 504 to 511, 602 to 607, 631, 632, 633, 635 to 640 and 650 to 654 inclusive and Article IX of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."

(2) Sections 101 to 109, 203, 204, 205, 207, 208, 209, 210 to 215, 300 to 331, 337.1 to 355, 605, 606, 610 and Article XIV of this act.

(3) Sections 1 to 10 of the act of July 11, 1917 (P.L.804), entitled "An act relating to domestic and foreign insurance companies and corporations holding and dealing in insurance stock and certificates; regulating the sale of stock and evidences of indebtedness of such companies and corporations, and of subscriptions and applications therefor; and prescribing penalties."

(4) Section 1 of the act of July 12, 1935 (P.L.969), entitled "An act providing for the valuation of bonds and other evidences of debt held by domestic insurance corporations and by foreign insurance corporations authorized to do business in this State."

(5) Sections 1, 2 and 3 of the act of March 4, 1850 (P.L.126), entitled "An act to supply lost policies of insurance."

(6) Sections 1 and 2 of the act of May 5, 1921 (P.L.350), entitled "An act making it unlawful to give or offer money to secure proxies for use at meetings of insurance companies."

(7) Section 1 of the act of June 22, 1931 (P.L.622), entitled "An act to prevent fraudulent procedure in obtaining licenses or certificates from the Insurance Department, or altering licenses or certificates issued by the Insurance Department; and providing penalties."

(8) Sections 1 to 4 of the act of May 22, 1945 (P.L.828), entitled "An act to enable domestic stock and mutual insurance companies to comply with the taxing statutes, and to relieve officers, directors and trustees of domestic stock and mutual insurance companies of personal liability by reason of the payment or determination not to contest payment of any license, excise, privilege, premium, occupation, or other fee, or tax, imposed by any State or political subdivision thereof."

(9) Sections 1 to 6 of the act of May 20, 1949 (P.L.1491), known as the "Unauthorized Insurers Process Act."


(11) Sections 1 to 10 of the act of February 21, 1961 (P.L.33), entitled "An act imposing a State tax on gross premiums, premium deposits, and assessments received from business transacted within this Commonwealth by certain insurance companies, associations, and exchanges; requiring the
filing of annual and tentative reports and the computation and payment of tax; providing for the rights, powers and duties of the Department of Revenue, the taxpayers and officers thereof; and providing penalties."

(754 amended Feb. 17, 1994, P.L.92, No.9)

Section 755. Investment Plan.--Any title insurance company subject to the provisions of this act is required to have a formal investment plan which shall be updated on an annual basis as authorized by the board of directors. The investment plan shall include, at a minimum, a description of the investment strategy of the company designed to provide for liquidity and diversity of the investment portfolio. The investment plan, and such other information as the Insurance Department may require in order to determine the impact of the investment plan on the solvency of the company, shall be made available to the Insurance Department during the course of a financial condition examination conducted in accordance with the laws pertaining to the conduct of examinations.

(755 added Dec. 18, 1992, P.L.1519, No.178)

ARTICLE VIII.

MUTUAL COMPANIES OTHER THAN MUTUAL LIFE COMPANIES.

Section 801. Licensing of Foreign Companies.--Any mutual insurance company, other than a mutual life company, organized outside of this Commonwealth, and authorized to transact the business of insurance on the mutual plan, may, on application, be admitted to transact the kinds of insurance authorized by its charter or articles of association, to the extent and with the powers and privileges specified in this act, when it shall be solvent under this act and shall have otherwise complied with the provisions of law applicable to such companies. If organized without the United States, it shall make and maintain the deposit required of stock insurance companies formed without the United States transacting the same kind of insurance.

Upon compliance, by any such foreign company, with the provisions of this act, such company may be granted a certificate of authority to transact business in this Commonwealth, subject to all the provisions of law relating to information to and examinations by the Insurance Commissioner, annual reports, taxes, and the renewal of certificates of authority, applicable to stock insurance companies transacting the same kinds of insurance, except as otherwise provided in this article.

(801 amended July 12, 1935, P.L.962, No.309)


Section 802.1. Investment of Assets.--Every domestic mutual insurance company, other than a mutual life insurance company, shall invest and keep invested all its funds in accordance with the laws of this Commonwealth relating to the investment of funds of domestic stock fire, stock marine, or stock fire and marine insurance companies. Provided, however, That any mutual insurance company which does not possess a certificate of authority to issue nonassessable insurance policies shall be permitted to invest its funds in assets specified in subsection (a)(3), (6), (7), (8), (9), (10), (11) and (12) of section 518C only after obtaining prior written approval of the Insurance Commissioner.


Section 803.1. Real Estate Which May Be Acquired, Held and Conveyed.--A domestic mutual insurance company, other than a mutual life insurance company, may acquire by purchase, lease or otherwise or receive, hold or convey real estate, or any interest therein, in accordance with the laws of this Commonwealth relating to real estate that may be acquired by purchase, lease or otherwise or received, held or conveyed by stock fire, stock marine, or stock fire and marine insurance companies. Mutual insurance companies which do not possess a certificate of authority to issue nonassessable insurance policies may only invest in such real estate necessary for the convenient accommodation of its business and may maintain cash balances necessary for the transaction of its business.


Section 804. Policy Provisions.--Mutual insurance companies, other than mutual life companies, may insert, in any form of policy prescribed by the law of this Commonwealth, any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with any law of this Commonwealth. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law; and a copy of such policy and endorsements, if any, shall have been first filed with, and shall not have been disapproved by, the Insurance Commissioner.


Section 806. Premiums.--The "maximum premium" payable by any member of a mutual insurance company, other than a mutual life insurance company, shall be expressed in the policy, or in the application for the insurance if attached to the policy. Such maximum premium shall be a cash premium and an additional contingent premium not less than the cash premium, or may be solely a cash premium. No policy shall be issued for a cash premium without an additional contingent premium, unless the company has and maintains a surplus which is not less in amount than the minimum capital required of domestic stock insurance companies authorized to transact the same class or classes of insurance.

(806 amended Nov. 27, 1968, P.L.1118, No.349)

Section 806.1. Certificate of Authority for the Issuance of Nonassessable Policies.--(a) Before a domestic mutual insurance company other than a mutual life insurance company may issue a nonassessable policy, the company shall furnish the Insurance Commissioner a certified copy of the resolution of the Board of Directors authorizing the issuance of nonassessable policies, and shall certify that the company possesses surplus as required in section 806 and that the company is otherwise qualified under its charter and by-laws. When the Insurance Commissioner is satisfied that the company has the above surplus and other qualifications, the commissioner shall issue to such company a certificate of authority for the issuance of nonassessable policies. This certificate shall continue in effect until rescinded or revoked as provided in this section.

(b) If a resolution of the board of directors authorizing the issuance of nonassessable policies is modified, the company shall furnish the Insurance Commissioner a certified copy of the modified resolution within fifteen (15) days after the end
of the month in which the modified resolution was adopted. If a resolution authorizing the issuance of nonassessable policies is rescinded, the company shall file with the Insurance Commissioner an application for termination of authority to issue nonassessable policies within fifteen (15) days after the end of the month in which the resolution was rescinded. An application for termination of authority to issue nonassessable policies shall include a certified copy of the rescinding resolution and any other information the commissioner may require.

(c) The Insurance Commissioner may, after hearing, revoke the certificate of authority to issue nonassessable policies if the commissioner finds that the company does not have the surplus as provided in section 806, or that the company is no longer qualified to issue nonassessable policies.

(d) No company may issue a nonassessable policy after:

1. the date the company revokes the resolution of the board of directors providing for the issuance of nonassessable policies; or
2. the revocation of the company's certificate of authority to issue nonassessable policies by the Insurance Commission.

(e) A nonassessable policy issued while a company has a valid certificate of authority to issue nonassessable policies shall remain nonassessable under all conditions, including, but not limited to, the revocation of the company's certificate of authority to issue nonassessable policies, any surplus deficiency of the company, and the liquidation or rehabilitation of the company.

(806.1 amended Dec. 18, 1996, P.L.1003, No.154)

Section 806.2. Violations and Penalties.--Any officer or director who is guilty of wilfully making a false certification that the company possesses the surplus as required in section 806 shall, upon conviction thereof, be punished by a fine of not less than one thousand dollars ($1000) nor more than five thousand dollars ($5000) or imprisonment for not more than one year, or both.

(806.2 added July 3, 1957, P.L.456, No.254)

Section 807. Reserves.--A mutual insurance company, other than a mutual life company, shall maintain unearned premium and other reserves separately, for each kind of insurance, upon the same basis as that required of domestic stock insurance companies transacting the same kind of insurance, except that the Insurance Commissioner may, by written order, fix a different basis of reserve for losses and claim in workmen's compensation insurance. Any reserve for losses or claims based upon the premium income shall be computed upon the net premium income, after deducting any so-called dividend or premium returned or credited to the member. The provisions relating to unearned premium reserve shall not apply to policies issued by a domestic mutual fire insurance company under the authority of section 202 (b) (1), which policies set forth therein, or in the promissory note attached thereto, a limited or unlimited liability to assessment. Such companies shall accumulate such reserves not later than December 31, 1976.

(807 amended July 9, 1976, P.L.947, No.183)

Section 808. Assessments.--A mutual insurance company, other than a mutual life company, not possessed of assets at least equal to the unearned premium reserve and other liabilities, shall make an assessment upon its members liable to assessment to provide for such deficiency. Such assessment shall be against each member in proportion to such liability as expressed in his policy. No member shall be assessed for any loss that occurred
when his policy was not in effect and no assessment shall be made after two years from the expiration or cancellation date of a policy and no such assessment shall be made without the prior written approval of the Insurance Commissioner. For each year the policy is in force, such assessment shall be an amount not greater than the annual or the average yearly cost or premium of the policy for the period it has been in effect. Such assessment shall not exceed two times the average yearly cost or premium of the policy for the period it has been in effect. The Insurance Commissioner may, by written order, relieve the company from an assessment or other proceedings to restore such assets during the time fixed in such order. Any domestic company which shall be deficient in providing the unearned premium reserve required hereby may, notwithstanding such deficiency, come under this act on the condition that it shall each year thereafter reduce such deficiency at least fifteen per centum (15%) of the original amount thereof, and in such case it may increase its assessments accordingly.

The provisions of this section are not applicable to assessments made upon the members of a company by the Insurance Commissioner pursuant to the authority granted him by Article V, act of May 17, 1921 (P.L. 789, No. 285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one."

(808 amended Dec. 30, 1974, P.L. 1045, No. 342)

Section 809. Loans to Companies.--(809 repealed Nov. 30, 2004, P.L. 1690, No. 216)

Section 810. On or after July 1, 1957, no mutual insurance company, other than a mutual life insurance company, shall transact any of the class of insurance mentioned in subdivision (c) (1) of section 202 of this act, until it shall have and shall maintain, at all times, a surplus over all liabilities including unearned premiums, computed in accordance with the laws of this Commonwealth, of not less than two hundred and fifty thousand dollars ($250,000.00): Provided, however, That nothing in this section shall be construed to reduce the requirements under section 806 of this act.

(810 added July 3, 1957, P.L. 460, No. 257)

ARTICLE VIII-A.

MUTUAL-TO-STOCK CONVERSION.

(Art. added Dec. 21, 1995, P.L. 714, No. 79)

Section 801-A. Short Title of Article.--This article shall be known and may be cited as the Insurance Company Mutual-to-Stock Conversion Act.

(801-A added Dec. 21, 1995, P.L. 714, No. 79)

Section 802-A. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Converted stock company." A Pennsylvania-domiciled stock insurance company that converted from a Pennsylvania-domiciled mutual insurance company under this article.

"Department." The Insurance Department of the Commonwealth.

"Eligible member." A member of a mutual company whose policy is in force on the date the mutual company's board of directors adopts a plan of conversion. A person insured under a group policy is not an eligible member. A person whose policy becomes effective after the board of directors adopts the plan but
before the plan's effective date is not an eligible member but shall have those rights established under section 809-A.

"Mutual company." A Pennsylvania domestic mutual insurance company that is seeking to convert to a stock insurance company under this article.

"Participating policy." A policy that grants a holder the right to receive dividends if, as and when declared by the mutual company.

"Person." An individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a similar entity or a combination of the foregoing acting in concert. (Def. added Dec. 21, 1998, P.L.1108, No.150)

"Plan of conversion" or "plan." A plan adopted by a mutual company's board of directors under this article to convert the mutual company into a stock company.

"Policy." An insurance policy, including an annuity contract.

"Stock company." A stock insurance company that meets all of the current requirements for admission to do business as a domestic Pennsylvania insurer. (802-A added Dec. 21, 1995, P.L.714, No.79)

**Compiler's Note:** Section 13(b) of Act 150 of 1998, which added the def. of "person", provided that the amendment of section 802-A shall not be applicable to any offer to acquire, announcement to acquire or acquisition of voting securities of a converted stock company, which coverted prior to the effective date of Act 150 or which converts after the effective date of Act 150 pursuant to an application filed in the Insurance Department prior to the effective date of Act 150.

Section 803-A. Adoption of Plan of Conversion.--(a) No plan of conversion shall become effective unless the mutual company seeking to convert to a stock company shall have adopted, by the affirmative vote of not less than two-thirds of its board of directors, a plan of conversion consistent with the requirements of sections 804-A, 805-A and 806-A. At any time before approval of a plan by the commissioner, the mutual company, by the affirmative vote of not less than two-thirds of its board of directors, may amend or withdraw the plan.

(b) Before a mutual company's eligible members may vote on approval of a plan, a mutual company whose board of directors has adopted a plan shall file all of the following documents with the commissioner within ninety (90) days after adoption of the plan:

(1) The plan of conversion, including the independent evaluation of pro forma market value required by section 804-A(d).

(2) The form of notice required by subsection (f).

(3) The form of proxy to be solicited from eligible members pursuant to subsection (g).

(4) The form of notice required by section 809-A to persons whose policies are issued after adoption of the plan but before its effective date.

(5) The proposed amended articles of incorporation and bylaws of the converted stock company.

(6) The acquisition of control statement, as required by section 1402.

(7) Such other information as the commissioner may request. Upon filing of the foregoing documents with the commissioner, the mutual company shall send to eligible members a notice
advising eligible members of the adoption and filing of the plan, their ability to provide the commissioner and the mutual company with comments on the plan within thirty (30) days of the date of such notice and procedure therefor.

(c) The commissioner shall immediately give written notice to the mutual company of any decision and, in the event of disapproval, a statement in detail of the reasons for the decision. The commissioner shall approve the plan if the commissioner finds each of the following:

(1) The plan complies with this article.
(2) The plan will not prejudice the interests of the members.
(3) The plan's method of allocating subscription rights is fair and equitable.
(d) The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing the plan and the independent evaluation of the pro forma market value required under section 804-A(d).

(e) The commissioner may order a hearing on whether the terms of the plan comply with this article after giving written notice to the mutual company and other interested persons, all of whom have the right to appear at the hearing.

(f) All eligible members shall be sent notice of the members' meeting to vote upon the plan. The notice shall briefly but fairly describe the proposed conversion plan, shall inform the member of his right to vote upon the plan and shall be sent to each member's last known address, as shown on the mutual company's records, at least thirty (30) days before the time fixed for the meeting. If the meeting to vote upon the plan is held during the mutual company's annual meeting of policyholders, only a combined notice of meeting is required.

(g) The plan shall be voted upon by eligible members and shall be adopted upon receiving the affirmative vote of at least two-thirds of the votes cast by eligible members. Members entitled to vote upon the proposed plan may vote in person or by proxy. The number of votes each eligible member may cast shall be determined by the mutual company's bylaws. If the bylaws are silent, each eligible member may cast one vote.

(h) The amended articles shall be considered at the meeting of the policyholders called for the purpose of adopting the plan of conversion and shall require for adoption the affirmative vote of at least two-thirds of the votes cast by eligible members.

(i) Documents to be filed following approval.--Within thirty (30) days after the eligible members have approved the plan, the converted stock company shall file both of the following documents with the commissioner:

(1) The minutes of the meeting of the eligible members at which the plan was approved.
(2) The amended articles of incorporation and bylaws of the converted stock company.


Compiler's Note: Section 13(b) of Act 150 of 1998, which amended the section 803-A, provided that the amendment of section 803-A shall not be applicable to any offer to acquire, announcement to acquire or acquisition of voting securities of a converted stock company, which convert prior to the effective date of Act 150 or which converts after the effective date of Act 150 pursuant
to an application filed in the Insurance Department prior to the effective date of Act 150.

Section 804-A. Required Provisions of Plan of Conversion.--(a) The following provisions shall be included in the plan:
   (1) The reasons for proposed conversion.
   (2) The effect of conversion on existing policies, including all of the following:
      (i) A provision that all policies in force on the effective date of conversion continue to remain in force under the terms of the policies, except that the following rights, to the extent they existed in the mutual company, shall be extinguished on the effective date of the conversion:
         (A) Any voting rights of the policyholders provided under the policies.
         (B) Except as provided under subparagraph (ii), any right to share in the surplus of the mutual company provided for under the policies.
         (C) Any assessment provisions provided for under the policies of the type described in section 808.
      (ii) Except as provided in subparagraph (iii), a provision that holders of participating policies in effect on the date of conversion continue to have a right to receive dividends as provided in the participating policies, if any.
      (iii) A provision that, except for the mutual company's life policies, guaranteed renewable accident and health policies and guaranteed renewable, noncancelable accident and health policies, upon the renewal date of a participating policy, the converted stock company may issue the insured a nonparticipating policy as a substitute for the participating policy.
   (3) The subscription rights to eligible members, including both of the following:
      (i) A provision that each eligible member is to receive without payment nontransferable subscription rights to purchase a portion of the capital stock of the converted stock company and that, in the aggregate, all eligible members shall have the right, prior to the right of any other party, to purchase one hundred per centum (100%) of the capital stock of the converted company, exclusive of any shares of capital stock required to be sold or distributed to the holders of surplus notes, if any, and capital stock purchased by the company's tax-qualified employe stock benefit plan that is in excess of the total price of the capital stock established under subsection (d), as permitted by section 806-A(c). As an alternative to subscription rights in the converted stock company, the plan may provide that each eligible member is to receive without payment nontransferable subscription rights to purchase a portion of the capital stock of one of the following:
         (A) a corporation organized for the purpose of purchasing and holding all the stock of the converted stock company;
         (B) a stock insurance company owned by the mutual company into which the mutual company will be merged; or
         (C) an unaffiliated stock insurance company or other corporation that will purchase all the stock of the converted stock company.
      (ii) A provision that the subscription rights shall be allocated in whole shares among the eligible members using a fair and equitable formula. This formula may, but need not, take into account how the different classes of policies of the eligible members contributed to the surplus of the mutual company or any other factors that may be fair or equitable.
(b) The plan shall provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights received under subsection (a)(3).

(c) The plan shall provide that any shares of capital stock not subscribed to by eligible members exercising subscription rights received under subsection (a)(3) shall be sold in a public offering through an underwriter. If the number of shares of capital stock not subscribed by eligible members is so small in number or other factors exist that do not warrant the time or expense of a public offering, the plan of conversion may provide for sale of the unsubscribed shares through a private placement or other alternative method approved by the commissioner that is fair and equitable to eligible members.

(d) The plan shall set the total price of the capital stock equal to the estimated pro forma market value of the converted stock company based upon an independent evaluation by a qualified expert. This pro forma market value may be that value that is estimated to be necessary to attract full subscription for the shares, as indicated by the independent evaluation and may be stated as a range of pro forma market value.

(e) The plan shall set the purchase price per share of capital stock equal to any reasonable amount. However, the minimum subscription amount required of any eligible member cannot exceed five hundred ($500) dollars, but the plan may provide that the minimum number of shares any person may purchase pursuant to the plan is twenty-five (25) shares.

(f) The plan shall provide that any person or group of persons acting in concert shall not acquire, in the public offering or pursuant to the exercise of subscription rights, more than five per centum (5%) of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in subsection (a)(3)(i), except with the approval of the commissioner. This limitation does not apply to any entity that is to purchase one hundred per centum (100%) of the capital stock of the converted company as part of the plan of conversion approved by the commissioner.

(g) The plan shall provide that no director or officer or person acting in concert with a director or officer of the mutual company shall acquire any capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in subsection (a)(3)(i), for three (3) years after the effective date of the plan, except through a broker-dealer, without the permission of the commissioner. This provision does not prohibit the directors and officers from making block purchases of one per centum (1%) or more of the outstanding common stock:

1. other than through a broker-dealer if approved in writing by the department;
2. through the exercise of subscription rights received under the plan; or
3. from participating in a stock benefit plan permitted by section 806-A(c) or approved by shareholders pursuant to section 811-A(b).

(h) The plan shall provide that no director or officer may sell stock purchased pursuant to this section or section 806-A(a) within one (1) year after the effective date of the conversion.

(i) The plan shall provide that the rights of a holder of a surplus note to participate in the conversion, if any, shall be governed by the terms of the surplus note.
The plan shall provide that, without the prior approval of the commissioner, no converted stock company, or any corporation participating in the conversion plan pursuant to subsection (a)(3)(i)(A) or (B), shall for a period of three (3) years from the date of the completion of the conversion repurchase any of its capital stock from any person, except that this restriction shall not apply to either:

1. A repurchase on a pro rata basis pursuant to an offer made to all shareholders of the converted stock company or any corporation participating in the conversion plan pursuant to subsection (a)(3)(i)(A) or (B);
2. A purchase in the open market by a tax-qualified or non-tax-qualified employee stock benefit plan in an amount reasonable and appropriate to fund the plan.

(804-A added Dec. 21, 1995, P.L.714, No.79)

Section 805-A. Closed Block of Business for Participating Life Policies.--(a) The plan shall provide that a mutual life insurance company's participating life policies in force on the effective date of the conversion shall be operated by the converted stock company for dividend purposes as a closed block of participating business, except that any and all classes of group participating policies may be excluded from the closed block.

(b) The plan shall provide that sufficient assets of the mutual company shall be allocated for the benefit of the closed block of business so that the assets, together with the revenue from the closed block of business, are sufficient to support the closed block, including, but not limited to, the payment of claims, expenses, taxes and any dividends that are provided for under the terms of the participating policies, with appropriate adjustments in the dividends for experience changes. The plan shall be accompanied by an opinion of a qualified actuary or an appointed actuary who meets the standards set forth in the insurance laws or regulations of this Commonwealth for the submission of actuarial opinions as to the adequacy of reserves or assets. The opinion shall relate to the adequacy of the assets allocated in support of the closed block of business. The actuarial opinion shall be based on methods of analysis deemed appropriate for those purposes by the Actuarial Standards Board.

(c) The amount of assets allocated for the benefit of the closed block shall be based upon the mutual life insurance company's last annual statement, updated to the last day of the quarter immediately preceding the effective date of the conversion.

(d) The converted stock company shall keep a separate accounting for the closed block and shall make and include in the annual statement to be filed with the commissioner each year a separate statement showing the gains, losses and expenses properly attributable to the closed block.

(e) Periodically, upon the commissioner's approval, those assets allocated to the closed block that are in excess of the amount of assets necessary to support the remaining policies in the closed block shall revert to the benefit of the converted stock company.

(f) The commissioner may waive the requirement for establishing a closed block of business if it is in the best interests of policyholders to do so. The commissioner may waive from inclusion in the closed block of participating policies those participating policies for which there is no expectation of dividends being paid if it is fair and equitable to do so.
Section 806-A. Optional Provisions of Plan of Conversion.--(a) The plan may provide that the directors and officers of the mutual company shall receive without payment nontransferable subscription rights to purchase capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 804-A(a)(3)(i). These subscription rights shall be allocated among the directors and officers by a fair and equitable formula and shall be subordinate to the subscription rights of eligible members. Nothing contained in this article shall require the subordination of subscription rights received by directors and officers in their capacity as eligible members, if any.

(b) The aggregate total number of shares that may be purchased by directors and officers of the mutual company in their capacity under subsection (a) and in their capacity as eligible members under section 804-A(a)(3)(i) shall not exceed thirty-five per centum (35%) of the total number of shares to be issued for a mutual company if total assets of the mutual company are less than fifty million ($50,000,000) dollars or twenty-five per centum (25%) of the total number of shares to be issued for a mutual company if total assets of the mutual company are more than five hundred million ($500,000,000) dollars. For mutual companies with total assets of or between fifty million ($50,000,000) dollars and five hundred million ($500,000,000) dollars, the percentage of the total number of shares that may be purchased shall be interpolated.

(c) The plan may allocate to a tax-qualified employe benefit plan nontransferable subscription rights to purchase up to ten per centum (10%) of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 804-A(a)(3)(i). A tax-qualified employe benefit plan is entitled to exercise subscription rights granted under this subsection regardless of the total number of shares purchased by other persons.

(d) The plan may provide for the creation of a liquidation account for the benefit of members in the event of voluntary liquidation subsequent to conversion in an amount equal to the surplus of the mutual company, exclusive of the principal amount of any surplus note, on the last day of the quarter immediately preceding the date of adoption of the plan.

Section 807-A. Alternative Plan of Conversion.--The board of directors may adopt a plan of conversion that does not rely in whole or in part upon issuing nontransferable subscription rights to members to purchase stock of the converted stock company if the commissioner finds that the plan does not prejudice the interests of the members, is fair and equitable and is not inconsistent with the purpose and intent of this act. An alternative plan may:

(1) Include the merger of a domestic mutual insurer into a domestic or foreign stock insurer.

(2) Provide for issuing stock, cash or other consideration to policyholders instead of subscription rights.

(3) Provide for partial conversion of the mutual company and formation of a mutual holding company.

(4) Set forth another plan containing any other provisions approved by the commissioner.
The department may approve a partial conversion and formation of a mutual holding company provided the mutual holding company is not insolvent or in hazardous financial condition according to information supplied in its most recent annual or quarterly statement filed with the department or as determined by a financial examination performed by the department pursuant to Article IX of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921." The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing whether the plan may be approved by the commissioner.


Section 808-A. Effective Date of Plan.--A plan is effective when the commissioner has approved the plan, the eligible members have approved the plan and adopted the amended articles of incorporation and the mutual company files the amended articles of incorporation in the office of the Secretary of the Commonwealth.

(808-A added Dec. 21, 1995, P.L.714, No.79)

Section 809-A. Rights of Members Whose Policies are Issued After Adoption of Plan and Before Effective Date.--(a) All members whose policies are issued after the proposed plan has been adopted by the board of directors and before the effective date of the plan shall be sent a written notice regarding the plan upon issuance of such policy.

(b) A member of a life or health insurance company entitled to be sent the notice described in subsection (a) is entitled to rescind the member's policy and receive a full refund of any amounts paid for the policy or contract within ten (10) days after he has received the notice. Except as provided in subsection (c) each member of a property or casualty insurance company entitled to receive the notice provided for in subsection (a) shall be advised of the member's right of cancellation and to a pro rata refund of unearned premiums.

(c) No member of a life or health insurance company or property or casualty insurance company who has made or filed a claim under his insurance policy shall be entitled to any right to receive any refund under subsection (b). No person who has exercised the rights provided by subsection (b) shall be entitled to make or file any claim under his insurance policy.

(809-A added Dec. 21, 1995, P.L.714, No.79)

Section 810-A. Corporate Existence.--(a) On the effective date of the conversion, the corporate existence of the mutual company continues in the converted stock company. On the effective date of the conversion, all the assets, rights, franchises and interests of the mutual company in and to every species of property, real, personal and mixed, and any accompanying things in action, are vested in the converted stock company, without any deed or transfer and the converted stock company assumes all the obligations and liabilities of the mutual company.

(b) Unless otherwise specified in the plan of conversion, the persons who are directors and officers of the mutual company on the effective date of the conversion shall serve as directors and officers of the converted stock company until new directors and officers of the converted stock company are elected pursuant to the articles of incorporation and bylaws of the converted stock company.

(810-A added Dec. 21, 1995, P.L.714, No.79)

Section 811-A. Conflict of Interest.--(a) A director, officer, agent or employe of the mutual company shall not receive any fee, commission or other valuable consideration,
other than his usual regular salary or compensation, for aiding, promoting or assisting in a conversion under this article except as provided for in the plan approved by the commissioner. This provision does not prohibit the payment of reasonable fees and compensation to attorneys, accountants and actuaries for services performed in the independent practice of their professions, even if the attorney, accountant or actuary is also a director or officer of the mutual company.

(b) For a period of two (2) years after the effective date of the conversion, no converted stock company shall implement any non-tax-qualified stock benefit plan unless the plan is approved by a majority of votes eligible to be cast at a meeting of shareholders held not less than six (6) months after the effective date of the conversion.

(c) All the costs and expenses connected with a plan of conversion shall be paid for or reimbursed by the mutual company or the converted stock company. However, if the plan provides for participation by another corporation or stock company in the plan pursuant to section 804-A(a)(3)(i), the corporation or stock company may pay for or reimburse all or a portion of the costs and expenses connected with the plan.

(811-A added Dec. 21, 1995, P.L.714, No.79)

Section 812-A. Failure to Give Notice.--If the mutual company complies substantially and in good faith with the notice requirements of this article, the mutual company's failure to send a member the required notice does not impair the validity of any action taken under this article.

(812-A added Dec. 21, 1995, P.L.714, No.79)

Section 813-A. Limitation on Actions.--Any action challenging the validity of or arising out of acts taken or proposed to be taken under this article shall be commenced no later than thirty (30) days after the later of the approval of the plan by the commissioner or the adoption of the plan by a vote of the eligible members.


Section 814-A. Mutual Company Insolvent or in Hazardous Financial Condition.--If a mutual company seeking to convert is insolvent or is in hazardous financial condition according to information supplied in its most recent annual or quarterly statement filed with the department, or as determined by a financial examination performed by the department pursuant to Article IX of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921," the requirements of this article, including notice to and policyholder approval of the plan of conversion, may be waived at the discretion of the commissioner, if requested by the mutual company, if the commissioner deems appropriate. If a waiver under this section is ordered by the commissioner, if the mutual company shall specify in its plan of conversion:

(1) The method and basis for the issuance of the converted stock company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the converted stock company to a sound financial condition.

(2) That the conversion shall be accomplished without granting subscription rights or other consideration to the past, present or future policyholders.

Nothing contained in this section shall alter or limit the authority of the commissioner under any of the provisions of law, including, but not limited to, Article V of "The Insurance Department Act of 1921."

Section 815-A. Rules and Regulations.--The commissioner may promulgate rules and regulations to administer and enforce this article.

(815-A added Dec. 21, 1995, P.L.714, No.79)

Section 816-A. Laws Applicable to Converted Stock Company.--(a) No mutual company shall be permitted to convert under this article if as a direct result of the conversion any person or any affiliate thereof acquires control of the converted stock company, unless that person and his affiliates comply with the provisions of section 1402. For purposes of this subsection, "control" shall have the meaning given to such term in section 1401.

(b) Except as otherwise specified in this article, a stock company converted under this article shall have and may exercise all the rights and privileges and shall be subject to all of the requirements and regulations imposed upon stock insurance companies formed under this act and any other laws of this Commonwealth relating to the regulation and supervision of insurance companies, but it shall exercise no rights or privileges which other stock insurance companies may not exercise.

(816-A added Dec. 21, 1995, P.L.714, No.79)

Section 817-A. Commencement of Business as a Stock Insurance Company.--No mutual company shall have the power to engage in the business of insurance as a stock company until it complies with all provisions of this article.

(817-A added Dec. 21, 1995, P.L.714, No.79)

Section 818-A. Amendment of Policies.--A mutual company, by endorsement or rider approved by the commissioner and sent to the policyholder, may simultaneously with or at any time after the adoption of a plan of conversion amend any outstanding insurance policy for the purpose of extinguishing the right of the holder of any such policy to share in the surplus of the mutual company. However, this amendment shall be null and void if the plan of conversion is not submitted to the commissioner or, if submitted, is disapproved by the commissioner or, if approved by the commissioner, is not approved by the eligible members on or before the first anniversary of its approval by the commissioner.

(818-A added Dec. 21, 1995, P.L.714, No.79)

Section 819-A. Prohibition on Acquisitions of Control.--Except as otherwise specifically provided in section 804-A, from the date a plan of conversion is adopted by the board of directors of a mutual insurance company until the effective date of the plan of conversion, no person shall directly or indirectly offer to acquire, make any announcement to acquire or acquire in any manner, including making a filing with the department for such acquisition under a statute or regulation of this Commonwealth, the beneficial ownership of ten per centum (10%) or more of a class of a voting security of the converted stock company or of a person which controls the voting securities of the converted stock company.


Compiler's Note: Section 13(b) of Act 150 of 1998, which added section 819-A, provided that section 819-A shall not be applicable to any offer to acquire, announcement to acquire or acquisition of voting securities of a converted stock company, which converted prior to the effective date of Act 150 or which converts after the effective date of Act 150 pursuant to an application
filed in the Insurance Department prior to the effective date of Act 150.

ARTICLE IX.

LLOYDS ASSOCIATIONS.

Section 901. Insurance on Lloyds Plan
Authorized.--Individuals partnerships, or associations of individuals, hereby designated underwriters, are authorized to engage in the business of insurance in this Commonwealth as insurers on the Lloyds plan, in accordance with the provisions of this act, but not otherwise.

Section 902. Purposes.--Such underwriters, when authorized as hereinafter provided, may insure the following classes of risks:

(a) On dwelling houses, stores, and all kinds of buildings and household furniture and other property,--against loss or damage, including loss of use or occupancy, by fire, lightning, and explosion, whether fire ensue or not, except explosion on risks specified in paragraph (5) of subdivision (c) of section two hundred and two (202), and by tornadoes, cyclones, windstorms, earthquakes, hail, frost, sleet, snow, or flood; against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus, erected for extinguishing fires, and of waterpipes; against accidental injury to such sprinklers, pumps, or other apparatus; against loss or damage caused by the caving in of the surface of the earth above coal-mines; and against loss or damage caused by bombardment, invasion, insurrection, riot, civil war, or commotion, and military or usurped power; and to effect reinsurance of any risk provided for in this clause.

(b) Upon vessels, boats, cargoes, goods, merchandise, freight, and other property,--against loss or damage by all or any of the risks of lake, river, canal, and inland navigation and transportation; upon automobiles, airplanes, seaplanes, dirigibles, or other aircraft, whether stationary or in operation or in transit, against loss or damage by fire, explosion, transportation, collision, or by burglary, larceny, or theft; not including, in any case, insurance against loss by reason of bodily injury to the person; and to effect reinsurance of any risk provided for in this clause.

(c) Upon vessels, freight, goods, wares, merchandise, specie, bullion, jewels, profits, commissions, bank notes, bills of exchange, and other evidence of debt, bottomry and respondentia interests, and every insurance appertaining to or connected with marine risks, and risks of transportation and navigation; and to effect reinsurance of any risk provided for in this clause.

(d) Any form of insurance, other than life insurance, not included in this section, if such insurance is not contrary to law, and is allied or in harmony with the classes of insurance herein provided. Such additional insurance shall be transacted only on express license by the Insurance Commissioner, and upon such terms and conditions as are from time to time prescribed by him.

Section 903. Filing of Declaration; Contents.--Such underwriters shall file with the Insurance Commissioner a declaration, signed and sworn to by their duly authorized attorney or attorneys-in-fact, setting forth:

(a) The name or title under which the business is to be conducted, which name shall not be so similar to any existing
association of insurers on the Lloyds or inter-insurance plan, or insurance corporations, as in the opinion of the Insurance Commissioner is calculated to deceive.

(b) The location of the principal office at which the business is to be conducted.

c) A copy of the form of power of attorney, agreement, or other authority of the attorney or attorneys-in-fact, setting forth the character of their representatives and their authority and the agreement between the underwriters.

(d) Copies of the forms of policy, contracts, or agreements under or by which insurance is to be effected.

e) The names and addresses of all the underwriters proposing to engage in such business.

(f) If a foreign association, the designation and appointment of the Insurance Commissioner for service of legal process.

(g) The kind or kinds of insurance to be written.

(h) That a fund for the protection of policyholders is in the possession, within the United States, of the attorney or attorneys-in-fact, or a committee for such underwriters, and is either in cash or invested as required by the laws of the State in which the principal office of the underwriters is located in respect to securities deposited by the insurance corporations authorized to transact similar kinds of insurance. Such fund shall amount to the sum of one hundred thousand dollars ($100,000), if the applicants desire to be authorized to transact the kind of insurance specified in any one of the subdivisions (a), (b), or (c), or in subdivisions (a) and (c), or (b) and (c), of section nine hundred and two (902) of this act; and such fund to amount to the sum of two hundred thousand dollars ($200,000), if the applicants desire to be authorized to transact all the kinds of insurance specified in subdivisions (a), (b), and (c), or in subdivisions (a) and (b) of said section.

(i) The number of underwriters, which shall not be less than twenty-five (25), and that each underwriter is worth, in his own right, not less than twenty thousand dollars ($20,000), over and above all his debts and liabilities.

(j) A statement showing a list of all cash and invested assets owned by said associated underwriters, as such, and their estimated value.

The Insurance Commissioner may, in his discretion, by a writing to be filed and kept in the Insurance Department, waive the filing of any part of the declaration mentioned on the part of such underwriters as are lawfully doing business in this Commonwealth at the time this act takes effect and who have heretofore filed such duly verified information with the said commissioner.

Section 904. Certificate To Do Business.--Upon the filing of the documents hereinbefore specified, the Insurance Commissioner shall examine the same, and, if it shall appear that all the statements made in the said declaration are true and that the rights of the policyholders will be protected thereunder, he may issue a certificate of authority to such underwriters, under the name chosen and approved, stating that they are authorized to transact the business of insurance specified in said declaration. Such certificate of authority shall be renewed annually; and no underwriter, attorney-in-fact, agent, or other person shall transact the business of insurance in this Commonwealth for such underwriters until such certificate has been issued, nor during its suspension or revocation.
Section 905. Examination by Insurance Commissioner.--Prior to the issuance of such certificate of authority, the Insurance Commissioner may, at his option, cause an examination to be made of the affairs and assets of the underwriters applying for said certificate.

Section 906. Deposits by Alien Underwriters.--If any of the underwriters applying for certificate of authority hereunder is not a citizen of the United States, each such alien underwriter shall, at the time of the making of the aforesaid application for certificate of authority, deposit with the Insurance Commissioner the sum of five thousand dollars ($5,000) in cash, or in securities such as are now required for the investment of the capital of insurance corporations authorized to do similar kinds of insurance business in this Commonwealth, or in such kinds of securities as may be approved by him. The provisions of this section as to deposits shall not apply if such alien underwriter is one of an association of underwriters having on deposit with the insurance department of any State of the United States, or in the hands of a bank or trust company as trustee, a cash deposit or approved securities, worth not less than one hundred thousand dollars ($100,000), held in trust for the benefit of all their policyholders in the United States; nor shall this section as to deposits apply if such alien underwriter is one of an association of underwriters nine-tenths of whom are at all times citizens of the United States, and who have complied with all other provisions of this act.

Section 907. Return of Deposits.--After the conditions of any deposits made under the provisions of this act have been fulfilled, and the certificate of authority granted to such underwriters has been canceled, or they have voluntarily withdrawn from and have ceased doing business in this Commonwealth, the Insurance Commissioner shall return to said underwriters, or their duly authorized representative for this purpose specifically designated by them, or their principal attorney or attorneys-in-fact, all securities and cash so deposited in this Commonwealth.

Section 908. Additional and Substituted Underwriters.--Whenever underwriters, applying for certificates of authority hereunder, after the issue of such certificate, are joined by other underwriters, additional or substituted, such additional or substituted underwriters must comply with the provisions of this act, and shall be held to be bound by the documents on file with the Insurance Commissioner concerning such authorized underwriters, in the same manner and to the same extent as though they had been original applicants for the certificates of authority.

Section 909. Information To Be Furnished to Insurance Commissioner.--Any association of underwriters authorized hereunder shall, from time to time, furnish to the Insurance Commissioner, under oath of their attorney or attorneys-in-fact, such information as said commissioner may require respecting the conduct of their affairs, changes in the name under which said business is done, the establishment of branch offices and their location, and any change in the membership of the underwriters and their attorney or attorneys-in-fact, including any amendment to the power of attorney, agreements, or articles of association of underwriters.

Section 910. Maximum Amounts of Risks.--No association of underwriters, authorized to do business in this Commonwealth under the terms hereof, shall expose themselves to loss on any one risk to an amount in excess of one-fifth of their cash and invested assets, including therein the underwriting liability
of the individual underwriters, unless any excess shall be promptly reinsured by said underwriters.

Section 911. Supervision by and Reports to Insurance Commissioner; Taxation.--All associations of underwriters authorized hereunder and their representatives shall, respectively, be subject to the same supervision by, and required to make the same reports to, the Insurance Commissioner, as is required of foreign insurance companies and their representatives transacting the same or similar kinds of insurance in this Commonwealth; and they shall pay the same taxes and license fees as are required to be paid by such insurance companies.

Section 912. Inter-Insurances and Reciprocal Underwriters Excepted from Article.--Nothing contained in this article shall apply to inter-insurers or reciprocal underwriters.

Section 913. Revocation and Suspension of Certificate of Authority.--Upon violation of any of the provisions of this article, the Insurance Commissioner shall have authority to revoke or suspend any certificate of authority issued hereunder.

Section 914. Penalty.--Any person who, as principal, attorney, agent, broker, or other representatives, shall engage in the business contemplated by this article, or any variety or part thereof, without complying with the requirements thereof, or who shall violate any provisions of this article, shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to pay a fine not exceeding five hundred dollars ($500).

ARTICLE X.

RECIPROCAL AND INTER-INSURANCE EXCHANGES.

Section 1001. Exchange of Contracts Authorized.--Individuals, partnerships, and corporations of this Commonwealth, hereby designated subscribers, are hereby authorized to exchange reciprocal or inter-insurance contracts with each other, or with individuals, partnerships, and corporations of other States and countries, providing indemnity among themselves from any loss which may be insured against under any provision of the insurance laws excepting life insurance.

Section 1002. Corporations Authorized To Exchange Contracts.--Any corporation, now or hereafter organized under the laws of this Commonwealth, shall, in addition to the rights, powers, and franchises specified in its article of incorporation, have full power and authority to exchange insurance contracts of the kind and character herein mentioned. The right to exchange such contracts is hereby declared to be incidental to the purpose for which such corporations are organized and as much granted as the rights and powers expressly conferred.

Section 1003. Execution of Contracts.--Such contracts may be executed by an attorney, agent, or other representative, herein designated attorney, duly authorized and acting for such subscribers.

(1003 repealed insofar as it applies to title insurance companies or the business of title insurance Aug. 14, 1963, P.L.922, No.439)

Section 1004. Declaration To Be Filed with Insurance Commissioner; Contents.--Such subscribers, so contracting among themselves, shall, through their attorney, file with the
Insurance Commissioner of this Commonwealth a declaration verified by the oath of such attorney, setting forth:

(a) The name or title of the office at which such subscribers propose to exchange such indemnity contracts. Such name or title shall not be so similar to any other name or title previously adopted by a similar exchange or association or by any insurance company as, in the opinion of the Insurance Commissioner, is calculated to result in confusion or deception.

(b) The kind or kinds of insurance to be effected or exchanged.

(c) A copy of the form of policy, contract, or agreement, under or by which such insurance is to be effected or exchanged.

(d) A copy of the form of power of attorney, or other authority of such attorney, under which such insurance is to be effected or exchanged, and which shall provide that the liability of the subscribers, exchanging contracts of indemnity, shall make provision for contingent liability, equal to not less than one additional annual premium or deposit charged: Provided, however, That where an exchange has a surplus equal to the capital and surplus required of a stock insurance company transacting the same kind or kinds of business, its power of attorney need not provide for such contingent liability of subscribers, and such exchange, so long as it maintains such surplus, may issue to its subscribers policies or contracts without contingent liability. ((d) amended Dec. 18, 1992, P.L.1519, No.178)

(e) The location of the office or offices from which such contracts or agreements are to be issued.

(f) That applications have been made for indemnity upon at least one hundred (100) separate risks, aggregating not less than one and one-half million ($1,500,000) dollars, as represented by executed contracts or bona fide applications to become concurrently effective, or, in case of employees' liability or compensation insurance, covering a total payroll of not less than one and one-half million ($1,500,000) dollars.

(g) That there is in the possession of such attorney, and available for the payment of losses, a sum of not less than one hundred thousand ($100,000) dollars.

(1004 amended June 24, 1939, P.L.683, No.318)

Section 1005. Certificate of Attorney.--Each attorney, by or through whom are issued any policies of or contracts for indemnity of the character referred to in this article, shall procure from the Insurance Commissioner, annually, a certificate of authority, stating that all the requirements of this act have been complied with; and, upon the payment of the fees required by this act, the Insurance Commissioner shall issue such certificate. The Insurance Commissioner may revoke or suspend any certificate of authority issued hereunder.

Section 1006. Certain Statements To Be filed by Attorney.--Such attorney shall file with the Insurance Commissioner a statement, under the oath of such attorney, showing the maximum amount of indemnity upon any single risk. Such attorney shall whenever he is required file with the Insurance Commissioner a statement, verified by his oath, to the effect that he has examined the commercial rating of such subscribers, as shown by the reference book of a commercial agency having at least one hundred thousand (100,000) subscribers, and that, from such examination or from other information in his possession, it appears that no subscriber has assumed on any single risk an amount greater than ten per centum (10%) of the net worth of such subscriber.
Section 1007. Reports by Attorney; Examinations by Insurance Commissioner.—Such attorney shall make a report to the Insurance Commissioner for each calendar year, on or before the first day of March, showing the financial condition of affairs at the office where such contracts are issued, and shall furnish such additional information and reports as he may require. Such attorney shall not be required to furnish the names and addresses of any subscribers, nor the loss ratio of any particular subscriber.

The business affairs and assets of such organizations shall be subject to examination by the Insurance Commissioner.

(1007 amended June 10, 1947, P.L.495, No.225)

Section 1008. Reserves.—There shall at all times be maintained as a reserve a sum in cash, or in securities of the character permitted by the laws of the State under which the exchange is organized for the investment of the capital and funds of an insurance company, equal to fifty per centum (50%) of the aggregate net annual deposits collected and credited to the account of the subscribers on policies having one year or less to run, and pro rata on those for longer periods. Net annual deposits shall be construed to mean the advance payments of subscriber, after deducting therefrom the amounts specifically provided in the subscribers' agreements for expenses. If said reserves at any time do not amount to one hundred thousand ($100,000) dollars, then there shall be maintained on deposit at the exchange at all times additional funds in cash or such securities which together with said reserves will equal one hundred thousand ($100,000) dollars. In calculating the foregoing reserves, the funds or amounts provided for in sub-section (g) section one thousand four, shall be included as part thereof. There shall also be maintained as a claim or loss reserve, cash or such securities, as authorized, sufficient to discharge all liabilities on all outstanding losses arising under policies issued. If at any time the amounts on hand are less than the foregoing requirements the subscribers or their attorney for them shall make up the deficiency under penalty of a revocation of the license. Such advances shall be repaid only out of the surplus funds of the exchange.

(1008 amended May 12, 1925, P.L.584, No.314)

Section 1008.1. Eligible Investments.—Every reciprocal and inter-insurance exchange shall invest and keep invested all its funds in accordance with the laws of this Commonwealth relating to the investment of funds of domestic stock fire, stock marine, or stock fire and marine insurance companies.


Section 1008.2. Real Estate Which May Be Acquired, Held and Conveyed.—No reciprocal and inter-insurance exchange shall acquire by purchase, lease or otherwise or receive, hold or convey real estate, or any interest therein, except in accordance with the laws of this Commonwealth relating to real estate that may be acquired by purchase, lease or otherwise or received held or conveyed by stock fire, stock marine, or stock fire and marine insurance companies.


Section 1009. Fees and Taxes.—Such attorney shall pay to the Commonwealth the same fees and taxes as are now required by law to be paid by stock and mutual companies transacting like kinds of business in this Commonwealth. In the payment of taxes, he may deduct, from the gross premiums or deposits received during the calendar year, all amounts returned to subscribers or credited to their accounts, other than for losses.

Section 1011. Penalty.--Any attorney who shall, except for the purpose of applying for certificate of authority as herein provided, exchange any contracts of indemnity of the kind and character specified in this article, or directly or indirectly solicit or negotiate any applications for same, without first complying with the foregoing provisions, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not less than one hundred ($100) dollars nor more than one thousand ($1,000) dollars.

ARTICLE X-A.

HEALTH CARE INSURANCE INDIVIDUAL ACCESSIBILITY.
(Art. added Nov. 4, 1997, P.L.492, No.51)

Section 1001-A. Purpose.--It is necessary to maintain the Commonwealth's sovereignty over the regulation of health insurance in this Commonwealth by complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936). This article is intended to meet those requirements while retaining the Commonwealth's authority to regulate health insurance in this Commonwealth.
(1001-A added Nov. 4, 1997, P.L.492, No.51)

Section 1002-A. Definitions.--(a) As used in this article, the following words and phrases shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Designated insurers." An insurer required to offer health coverage to eligible individuals under section 1003-A.

"Eligible individual." A resident of this Commonwealth who meets the definition in section 2741(b) of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).


"Fraternal benefit society." An entity holding a current certificate of authority in this Commonwealth under the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."

"Health maintenance organization" or "HMO." An entity holding a current certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

"Hospital plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Insurer." A foreign or domestic insurance company, association or exchange, health maintenance organization, hospital plan corporation, professional health services plan corporation, fraternal benefit society or risk-assuming preferred provider organization. The term does not include a group health plan as defined in section 2791 of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

"Medical loss ratio." The ratio of incurred medical claim costs to earned premiums.
"Preferred provider organization" or "PPO." An entity holding a current certificate of authority organized and operated under section 630 of this act.

"Professional health services plan corporation." An entity holding a current certificate of authority organized and operated under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations). The term does not include dental service corporations or optometric service corporations as defined under 40 Pa.C.S. § 6302(a) (relating to definitions).

(b) The words, terms and definitions found in the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), including, but not limited to, those definitions in section 2791 of that act, are hereby adopted for purposes of implementing this article unless otherwise provided by this article. The term "health insurance issuer" found in section 2791(b)(2) of the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) shall have the same meaning as "insurer" in subsection (a).

(1002-A added Nov. 4, 1997, P.L.492, No.51)

Section 1003-A. Designated Insurers.--(a) The following insurers shall comply with sections 1004-A and 1005-A in order to implement the alternative mechanism requirements of the Federal act:

(1) Hospital plan corporations.

(2) Professional health services plan corporations.

(b) If a designated insurer owns a hospital plan corporation or a professional health services plan corporation which provides services within substantially the same service area as the parent organization, the subsidiary hospital plan corporation and professional health services plan corporation are not required to offer coverage to eligible individuals if the parent organization offers coverage to eligible individuals under sections 1004-A and 1005-A.

(1003-A added Nov. 4, 1997, P.L.492, No.51)

Section 1004-A. Alternative Mechanism in Individual Market.--(a) A designated insurer shall:

(1) Offer continuous year-round open enrollment to eligible individuals.

(2) Offer to eligible individuals, upon request, a choice of at least two individual health insurance policies as specified in section 1005-A.

(3) Issue to eligible individuals, upon request, an individual policy that meets the requirements of section 1005-A.

(b) Unless an eligible individual chooses to purchase a policy pursuant to section 1005-A(c), a policy offered or issued to an eligible individual under section 1005-A shall not contain preexisting condition limitations or restrictions.

(c) Designated insurers shall provide financial subsidization of policies issued to eligible individuals. Designated insurers shall file for review by the commissioner a method for financial subsidization in all rate filings on policy choices for eligible individuals. The total subsidy provided by the designated insurer to all of its products shall not be affected by the requirement to subsidize products issued to eligible individuals.

(1004-A added Nov. 4, 1997, P.L.492, No.51)

Section 1005-A. Policy Choice for Eligible Individuals.--(a) Designated insurers shall offer eligible individuals a choice of policies. The choices shall include:

(1) At least one policy that is comparable to a standard health insurance policy or a comprehensive health insurance
policy being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(2) At least one other policy that is being actively marketed by the insurer to persons other than eligible individuals in the voluntary individual market.

(b) Each designated insurer shall file with and identify to the commissioner the comprehensive policy form or the standard policy form the insurer intends to offer to eligible individuals under subsection (a)(1). A designated insurer may elect to identify more than one comprehensive or standard policy form which will be offered to eligible individuals. Each policy form shall contain benefits and limits comparable to policies being actively marketed to persons other than eligible individuals in the voluntary individual market. The policy forms shall be considered comparable even if the policies marketed in the voluntary individual market include a preexisting condition exclusion.

(c) Nothing in this article shall prohibit an eligible individual from purchasing a policy which includes a preexisting condition provision or is not otherwise offered under this section from a designated insurer or any other insurer.

(1005-A added Nov. 4, 1997, P.L.492, No.51)

Section 1006-A. Coordination of Benefits.--Benefits provided under individual policies by an insurer may be subject to coordination of benefits with any other group policy, individual policy, Federal or State government program, labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan except as otherwise provided by law.

(1006-A added Nov. 4, 1997, P.L.492, No.51)

Section 1007-A. Excessive Loss Provision.--(a) At any time, the designated insurer may file for a rate adjustment for products offered under section 1005-A with the commissioner in accordance with the act of December 18, 1996 (P.L.1066, No.159), known as the "Accident and Health Filing Reform Act."

(b) The designated insurer may request that the commissioner conduct a hearing if:

(1) the losses experienced by the designated insurer on products offered under section 1005-A(a)(1) or by eligible individuals under section 1005-A(a)(2) require a rate increase of greater than twenty per centum (20%) and the losses are in excess of a one hundred ten per centum (110%) medical loss ratio for any calendar year; or

(2) the designated insurer requested a rate increase for products under section 1005-A(a) and has reason to believe that continuation as a designated insurer will have a detrimental impact on its financial condition or solvency.

(c) Upon the request of a designated insurer under subsection (b), the commissioner shall conduct a public hearing regarding the rate filing, medical loss ratio or the impact that being a designated insurer is having on the designated insurer's solvency. The hearing shall be held as provided for in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). Following the hearing, the commissioner shall determine the extent of the impact, if any, of being a designated insurer under this article on the designated insurer's rate filing, medical loss ratio, overall operations and solvency and shall do one or more of the following:

(1) grant, modify or deny the requested rate filing; or
(2) request to withdraw from the approved alternative mechanism and to authorize implementation of the Federal default standards set forth in section 2741 of the Federal act.

(1007-A added Nov. 4, 1997, P.L.492, No.51)

Section 1008-A. Review of Filings.--The department shall review filings submitted under sections 1004-A(c), 1005-A(b) and 1007-A(a) in accordance with the act of December 18, 1996 (P.L.1066, No.159), known as the "Accident and Health Filing Reform Act."

(1008-A added Nov. 4, 1997, P.L.492, No.51)

Section 1009-A. Conversion Policies.--(a) Notification of the conversion privilege shall be included with each certificate of coverage issued under section 621.2(d) and with any HMO subscriber agreement. Each certificate holder in an insured group and each HMO subscriber shall be given written notification of the conversion privilege and its duration within a period beginning fifteen (15) days before and ending thirty (30) days after the date of termination of the group coverage. The certificate holder or the holder's dependent and the HMO subscriber or the subscriber's dependent shall have no less than thirty-one (31) days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder or subscriber or mailed to the certificate holder's or subscriber's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section.

(b) The premium rates for individuals who purchase a comparable group conversion policy offered pursuant to applicable law shall be limited to one hundred twenty per centum (120%) of the approved premium rates for comparable group coverage.

(1009-A amended Dec. 20, 2000, P.L.967, No.132)

Section 1010-A. Penalties.--Upon satisfactory evidence of a violation of this article by an insurer or other person, the commissioner may pursue any one or more of the following penalties:

(1) Suspend, revoke or refuse to renew the license of the insurer or other person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than five thousand dollars ($5,000).

(4) Impose a civil penalty of not more than ten thousand dollars ($10,000) for a willful violation of this article.

(b) Penalties imposed on an insurer or other person under this article shall not exceed five hundred thousand dollars ($500,000) in the aggregate during a single calendar year.

(1010-A added Nov. 4, 1997, P.L.492, No.51)

Section 1011-A. Regulations.--The department may promulgate regulations as may be necessary or appropriate to carry out this article.

(1011-A added Nov. 4, 1997, P.L.492, No.51)

Section 1012-A. Expiration.--(1012-A deleted by amendment Nov. 2, 2006, P.L.1315, No.136)

ARTICLE X-B.

FAIRNESS IN MULTIPLE COPAYMENTS.

(Art. added July 31, 2015, P.L.170, No.39)

Section 1001-B. Declaration of intent.

The general purpose of this article is to provide fairness for persons seeking medically necessary physical therapy, chiropractic and occupational therapy who are sharing the cost
of the care pursuant to a health insurance policy by prohibiting
the imposition of multiple copayments for licensed physical
therapy, chiropractic and occupational therapy services.
(1001-B added July 31, 2015, P.L.170, No.39)

Section 1002-B. Definitions.
The following words and phrases when used in this article
shall have the meanings given to them in this section unless
the context clearly indicates otherwise:
"Chiropractic." As defined in section 102 of the act of
December 16, 1986 (P.L.1646, No.188), known as the Chiropractic
Practice Act.
"Copayment." A specific dollar amount a covered person must
pay for services rendered by a provider under a health benefit
plan.
"Health insurance policy." As follows:
(1) An individual or group health insurance policy,
contract or plan that provides medical or health care
coverage by a health care facility or licensed health care
provider that is offered by or is governed under any of the
following:
(i) This act.
(ii) The act of December 29, 1972 (P.L.1701,
No.364), known as the Health Maintenance Organization
Act.
(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan
corporations).
(iv) 40 Pa.C.S. Ch. 63 (relating to professional
health services plan corporations).
(2) The term does not include accident only, fixed
indemnity, limited benefit, credit, dental, vision, specified
disease, Medicare supplement, Civilian Health and Medical
Program of the Uniformed Services (CHAMPUS) supplement,
long-term care or disability income, workers' compensation
or automobile medical payment insurance.
"Occupational therapy." As defined in section 3 of the act
of June 15, 1982 (P.L.502, No.140), known as the Occupational
Therapy Practice Act.
"Physical therapy." As defined in section 2 of the act of
October 10, 1975 (P.L.383, No.110), known as the Physical
Therapy Practice Act.
(1002-B added July 31, 2015, P.L.170, No.39)

Section 1003-B. Limits on copayments.
A health insurance policy that is delivered, issued for
delivery, renewed, extended or modified in this Commonwealth
by a health care insurer for services provided by a licensed
physical therapist, chiropractor or occupational therapist
provider may not subject an insured to more than one copayment
amount per visit or deplete more than one visit with any one
visitor.
(1003-B added July 31, 2015, P.L.170, No.39)

Section 1004-B. Regulations.
The department may promulgate regulations as may be necessary
or appropriate to carry out the provisions of this article.
(1004-B added July 31, 2015, P.L.170, No.39)

Section 1005-B. Penalties.
A violation of this article by an insurer if committed
flagrantly and in conscious disregard of the provisions of this
article or with frequency sufficient to constitute a general
business practice shall be considered a violation of the act
of July 22, 1974 (P.L.589, No.205), known as the Unfair
Insurance Practices Act. A violation of this article is deemed
an unfair method of competition and an unfair deceptive act or practice pursuant to the Unfair Insurance Practices Act.

(1005-B added July 31, 2015, P.L.170, No.39)

Section 1006-B. Applicability.
This article shall apply as follows:
(1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the Insurance Department, this article shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.
(2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the Insurance Department, this article shall apply to any policy issued or renewed on or after 180 days after the effective date of this section.

(1006-B added July 31, 2015, P.L.170, No.39)

ARTICLE XI.
LONG-TERM CARE.


Section 1101. Statement of Purpose.--The purpose of this article is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies and to facilitate flexibility and innovation in the development of long-term care insurance coverage.


Section 1102. Scope of Article.--This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance need not meet the requirements of this article.

(1102 amended July 17, 2007, P.L.134, No.40)

Section 1103. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:
"Applicant." The term includes the following:
(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
(2) In the case of a group long-term care insurance policy, the proposed certificate holder.
"Benefit trigger." A contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For the purposes of a qualified long-term care insurance contract as defined in section 7702B of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 7702B), the term shall include a determination by a licensed health care practitioner the insured is a chronically ill individual. (Def. added July 9, 2010, P.L.362, No.51)
"Certificate." Any certificate issued under a group long-term care insurance policy which has been delivered or issued for delivery in this Commonwealth.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Functionally necessary." The appropriateness of services directed to address the individual's inability to perform tasks required for daily living, as defined through regulation, and the individual's need for continuous care or supervision.

"Group long-term care insurance." A long-term care insurance policy which is delivered or issued for delivery in this Commonwealth and issued to any of the following:

1. Employers or labor organizations or a trust or to the trustees of a fund established by employers or labor organizations for employees or former employees or for members or former members of the labor organizations.
2. Any professional, trade or occupational association for its members or former or retired members if the association:
   a. is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation; and
   b. has been maintained in good faith for purposes other than obtaining insurance.
3. An association or a trust or the trustee of a fund established or maintained for the benefit of members of associations. To qualify under this paragraph:
   a. The insurer of the association or associations must file evidence with the commissioner that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least one year and have a constitution and bylaws which provide that:
      (i) the association or associations hold regular meetings not less than annually to further purposes of the members;
      (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and
      (iii) the members have voting privileges and representation on the governing board and committees.
   b. Thirty (30) days after filing, the association or associations will be deemed to satisfy organizational requirements unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.
4. A group other than as described in clauses (1), (2) and (3) of this section, subject to a finding by the commissioner that:
   a. the issuance of the group policy is not contrary to the best interest of the public;
   b. the issuance of the group policy would result in economies of acquisition or administration; and
   c. the benefits are reasonable in relation to the premiums charged.

"Independent review organization." An organization that conducts independent reviews of long-term care benefit trigger decisions. (Def. added July 9, 2010, P.L.362, No.51)

"Long-term care insurance." Any insurance policy or rider advertised, marketed, offered or designed to provide comprehensive coverage for each covered person on an expense-incurred, indemnity, prepaid or other basis for
functionally necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term includes a policy, rider or prepaid home health or personal care service policy. The term includes group and individual policies or riders issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, health maintenance organizations or similar organizations. The term does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage or limited benefit health coverage. (Def. amended July 9, 2010, P.L.362, No.51)

"Medically necessary." The appropriateness of treatment of the insured's condition, including nonmedical support services, based on current standards of acceptable medical practice. The term may exclude benefits for care or services which are primarily for the convenience of the insured or the person's physician.

"Policy." Any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

"Prepaid home health or personal care service policy." A policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this Commonwealth to provide home health or personal care services. This term excludes:

1. Home health or personal care services administered through a local area agency on aging or as a government service or provided by a nonprofit association, organization or corporation other than a nonprofit health, hospital or medical service corporation.

2. A contract or arrangement which meets all of the following criteria:
   (i) Provides for services upon demand without regard to medical condition.
   (ii) Does not seek or utilize any form of medical questionnaire or information, written or verbal, for assessment of health condition for any reason.
   (iii) Provides for cost of services that is not based on any estimate or contingency of actual or anticipated use of services.
   (iv) Does not contain any waiting period.
   (v) Contains the following notice, verbatim in boldface, 18-point type on the face sheet to the contract:

This contract is not insurance; it is not to be used as a substitute or replacement for insurance; it provides none of the safeguards of insurance regulated by the Pennsylvania Insurance Department, such as a guarantee that all benefits or services will be fully funded. In the event of insolvency, there is no Pennsylvania Life and Health Insurance Guaranty Association protection.

Under Pennsylvania law, the service contract provider may not seek or use any medical information to determine your eligibility for purchasing this contract or to set rates under the contract. Further, the service contract provider must provide you with all contracted services upon demand,
without regard to your medical condition or medical necessity.

Any attempted or actual solicitation or sale of this product as a substitute for or replacement of a long-term care policy is a violation of Pennsylvania insurance laws, reportable to the Insurance Department of this Commonwealth. (Def. amended Nov. 30, 2004, P.L.1690, No.216)

Compiler's Note: Section 7 of Act 40 of 2007, which amended section 1103, provided that the amendment shall apply to all policies issued on or after the effective date of Act 40.

Section 1104. Limits of Group Long-term Care Insurance.--No group long-term care insurance coverage may be offered to a resident of this Commonwealth under a group policy issued in another state to a group described in clause (4) of the definition of "group long-term care insurance" in section 1103 unless the Commonwealth or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this Commonwealth has made a determination that such requirements have been met.


Section 1104.1. Prepaid Home Health or Personal Care Service Policies; Exempt Entities.--Any entity that solicits or provides prepaid home health or personal care service policies claiming to be exempt under this article shall, upon demand by the department, provide all books and records which, in the department's sole judgment, are necessary for the department to determine the entity's status as an exempt entity.

(1104.1 added Nov. 30, 2004, P.L.1690, No.216)

Section 1105. Disclosure and Performance Standards for Long-term Care Insurance.--(a) The department may adopt regulations, that include standards for full and fair disclosure setting forth the manner, content and required disclosures, for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(b) No long-term care insurance policy may:

(1) be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;
(2) contain a provision establishing a new waiting period, in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
(3) contain coverage for skilled nursing care only or contain coverage that provides significantly more skilled care than coverage for lower levels of care; or
(4) be marketed, offered or designed to provide coverage for less than twelve consecutive months.

((b) amended Nov. 30, 2004, P.L.1690, No.216)

(c) (1) No long-term care insurance policy or certificate may use a definition of "preexisting condition" which is more restrictive than a definition of "preexisting condition" that means a condition for which medical advice or treatment was recommended by or received from a provider of health care
services within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.


Section 1106. Commissioner's Duties.--The commissioner may extend the limitation periods set forth in section 1105 as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.


Section 1107. Underwriting Standards.--The definition of the term "preexisting condition" under section 1105(c) does not prohibit an insurer from using an application form designed to elicit the complete health history of the applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in section 1105(c)(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in section 1105(c)(2).


Section 1108. Prior Institutionalization.--No long-term care insurance policy shall:

(1) condition eligibility for any benefits on a prior stay in an institution or a prior chronic condition;

(2) condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) condition eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.


Section 1109. Loss Ratios.--The department may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(1109 added Dec. 15, 1992, P.L.1129, No.148)

Section 1110. Right to Return.--Individual long-term care insurance policyholders and group certificate holders who contribute to the cost of their long-term care coverage shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. Long-term care insurance policies and applicable group certificates shall have a notice, prominently printed on the first page of the policy or certificate, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.
Section 1110.1. Long-Term Care Partnership Program.--(a) There is hereby established the Long-Term Care Partnership Program, to be administered by the Department of Public Welfare in accordance with the requirements for qualified State long-term care insurance partnerships. The purpose of this program is to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid by providing incentives for individuals to ensure against the potentially substantial costs that arise upon the need for long-term care.  

(b) In order to implement the program, the Department of Public Welfare shall file a State plan amendment with Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) within 30 days of the effective date of this section. The program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured and administered by the Department of Public Welfare in accordance with Federal law and applicable Federal guidelines for qualified State long-term care partnerships.  

(c) The department shall require all insurers offering a qualified Long-Term Care Partnership Program policy to offer to exchange any policy or certificate issued between February 8, 2006, and the date the State plan amendment takes effect with a qualified Long-Term Care Partnership Program policy. The following shall apply:  

(1) All offers of exchange shall be subject to the outline of coverage provisions set forth under section 1111 and all applicable regulations.  

(2) Policies exchanged under this provision, if there is no change in coverage material to the risk, shall not be subject to any medical underwriting or approval process.  

(3) Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued.  

(4) Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.  

(5) Any addition to a policy as a result of any exchange shall be subject to the right to return set forth under section 1110 and all applicable regulations.  

(1110.1 added July 17, 2007, P.L.134, No.40)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.
(e) The outline of coverage shall include all of the following:
   (1) A description of the benefits and coverage provided in the policy.
   (2) A statement of the exclusions, reductions and limitations contained in the policy.
   (3) A statement of the terms under which the policy or certificate may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.
   (4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions.
   (5) A description of the terms under which the policy or certificate may be returned and premium refunded.
   (6) A brief description of the relationship of cost of care and benefits.


Section 1111.1. Appealing An Insurer's Determination the Benefit Trigger Is Not Met.--(a) An authorized representative is authorized to act as the covered person's personal representative within the meaning of 45 CFR § 164.502(g) (relating to uses and disclosures of protected health information: general rules) promulgated under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) and means the following:
   (1) a person to whom a covered person has given express written consent to represent the covered person in an external review;
   (2) a person authorized by law to provide substituted consent for a covered person; or
   (3) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(b) If an insurer determines the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of the following:
   (1) The reason the insurer determined the insured's benefit trigger has not been met.
   (2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request.
   (3) The insured's right to have the benefit trigger determination reviewed under the independent review process under subsection (d) after the exhaustion of the insurer's internal appeal process.

(c) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within one hundred twenty (120) calendar days after the insured and the insured's authorized representative, if applicable, received the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer provided the individual making the internal appeal decision may not be the same individual who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative.
representative, if applicable, within thirty (30) calendar days of the insurer's receipt of the necessary information upon which a final determination can be made:

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe additional internal appeal rights offered by the insurer. Nothing in this section shall require the insurer to offer internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in subsection (d) to the insured and the insured's authorized representative, if applicable.

(3) As part of the written description of the insured's right to request an independent review, an insurer shall include the following or substantially equivalent language:

We have determined that the benefit eligibility criteria ("benefit trigger") of your (policy) (certificate) has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at (address). You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance department's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it.

(4) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured, the insured's authorized representative, if applicable, and the department in writing and include in the notice the reasons for its determination of independent review ineligibility.

(5) The appeal process described in this subsection does not include a notice requirement as to the availability of new long-term care services or providers.

(d) (1) The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in subsection (c) has been exhausted. A written request for independent review may be made by the insurer or the insured's authorized representative to the insurer within one hundred twenty (120) calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

(2) The cost of the independent review shall be borne by the insurer.

(3) (i) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization the insured
or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the Commonwealth. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

(ii) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(A) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section.

(B) The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer.

(C) The review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(iii) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, the information shall first be considered in the internal review process, as set forth in subsection (c).

(A) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(B) The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the insurer's receipt of the new or additional information.

(C) If the insurer maintains its denial after such review, the independent review organization shall continue its review and render its decision within the time period specified in subparagraph (ix). If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(iv) The insurer shall acknowledge in writing to the insured, the insured's authorized representative, if applicable, and the department the request for independent review has been received, accepted and forwarded to an independent review organization for review. The notice will include the name and address of the independent review organization.

(v) Within five (5) business days of receipt of the request for independent review, the independent review organization assigned under this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer and the department it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement the insured or insured's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice.
information and supporting documentation the independent review organization should consider when conducting its review.

(vi) The independent review organization shall review all of the information and documents received under subparagraph (v) that have been provided to the independent review organization. The independent review organization shall provide copies of the documentation or information provided by the insured or the insured's authorized representative to the insurer for its review if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information under subparagraph (viii).

(vii) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider the information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide the new or additional information to the independent review organization for its review along with the insurer's analysis of the information.

(viii) If the insurer overturns its benefit trigger determination:

(A) The insurer shall provide notice to the independent review organization and the insured, the insured's authorized representative, if applicable, and the commissioner of its decision.

(B) The independent review process shall immediately cease.

(ix) The independent review organization shall provide the insured, the insured's authorized representative, if applicable, the insurer and the department written notice of its decision within thirty (30) calendar days from receipt of the referral referenced in paragraph (3)(ii). If the independent review organization overturns the insurer's decision, it shall:

(A) Establish the precise date within the specific period of time under review the benefit trigger was deemed to have been met.

(B) Specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met.

(C) For qualified long-term care insurance contracts, provide a certification the insured is a chronically ill individual. The certification shall be made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 7702B(c)(4)).

(x) The decision of the independent review organization regarding whether the insured met the benefit trigger shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the independent review organization's decision. There shall be a rebuttable presumption in favor of the decision of the independent review organization.

(xi) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions and is intended to be admissible in a proceeding only to the extent it establishes the eligibility of benefits payable.

(xii) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination
after the independent review decision, if the independent review organization upholds the insurer's decision.

(xiii) The department shall utilize the criteria established by the National Association of Insurance Commissioners for its guidelines for Long-Term Care Independent Review Entities in certifying entities to review long-term care insurance benefit trigger decisions.

(xiv) The department shall accept another state's certification of an independent review organization, provided the state requires the independent review organization to meet substantially similar qualifications as those established by the National Association of Insurance Commissioners.

(xv) The department shall maintain and periodically update a list of approved independent review organizations.

(e) The department shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

(1) Has on staff or contracts with a qualified and licensed health care professional in an appropriate field, such as physical therapy, occupational therapy, neurology, physical medicine or rehabilitation, for determining an insured's functional or cognitive impairment to conduct the review.

(2) Shall not be related to or affiliated with an entity previously providing medical care to the insured.

(3) Utilizes a licensed health care professional who is not an employe of the insurer or related to the insured.

(4) Shall not receive compensation of any type that is dependent on the outcome of the review and shall not utilize a licensed health care professional who receives compensation of any type that is dependent on the outcome of the review.

(5) Is approved or certified by the Commonwealth to conduct the reviews if the Commonwealth requires the approvals or certifications.

(6) Provides a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. The fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

(7) Provides the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(8) Has on staff or contracts with a licensed health care practitioner as defined under section 7702B(c)(4) of the Internal Revenue Code of 1986 who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(f) Each certified independent review organization shall comply with the following:

(1) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date the resolution was communicated to the insurer and the insured and the name and professional status of the reviewer conducting the review, in an easily accessible and retrievable format for the year in which it received the information plus two calendar years.

(2) Be able to document measures taken to appropriately safeguard the confidentiality of the records and prevent unauthorized use and disclosures under applicable Federal and State law.
(3) Report annually to the department by June 1 in the aggregate and for each long-term care insurer the following:
   (i) The total number of requests received for independent review of long-term care benefit trigger decisions.
   (ii) The total number of reviews conducted and the resolution of the reviews such as the number of reviews that upheld or overturned the long-term care insurer's determination the benefit trigger was not met.
   (iii) The number of reviews withdrawn prior to review.
   (iv) The percentage of reviews conducted within the prescribed timeframe set forth in subsection (c)(3).
   (v) The other information the department may require.

(4) Report immediately to the department a change in its status which would cause it to cease meeting a qualification required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

(g) Nothing in this section shall limit the ability of an insurer to assert rights an insurer may have under the policy related to:
   (1) An insured's misrepresentation.
   (2) Changes in the insured's benefit eligibility.
   (3) Terms, conditions and exclusions of the policy other than failure to meet the benefit trigger.

(h) The department shall compile and maintain a list of certified, qualified long-term care insurance independent review organizations and shall publish the list on its Internet website and annually in the Pennsylvania Bulletin by July 1.

(i) This section shall not apply to long-term care insurance claims made under a group long-term care insurance policy that is governed by the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), referred to as ERISA.

(1111.1 added July 9, 2010, P.L.362, No.51)

Compiler's Note: Section 10(1) of Act 51 of 2010, which added section 1111.1, provided that section 1111.1 shall apply to benefit trigger requests made on or after 60 days after the effective date of Act 51.

Section 1111.2. Prompt Payment of Clean Claims.--(a) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following:
   (1) the insurer is declining to pay all or part of the claim and the specific reason for denial; or
   (2) additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary.

(b) Within thirty (30) business days after receipt of the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice the insurer is declining to pay all or part of a claim and the specific reason or reasons for denial.

(c) If an insurer fails to comply with subsection (a) or (b), the insurer shall pay interest at the rate of one per centum (1%) per month on the amount of the claim that should have been paid but remains unpaid forty-five (45) business days after the receipt of the claim with respect to subsection (a) or all requested additional information with respect to subsection (b). The interest payable under this subsection shall be included in a late reimbursement without requiring the person
who filed the original claim to make an additional claim for the interest.

(d) The provisions of this section shall not apply to where the insurer has reasonable basis supported by specific information the claim was fraudulently submitted.

(e) A violation of section 1111.1 or this section by an insurer if committed flagrantly and in conscious disregard of the provisions of this act or with frequency sufficient to constitute a general business practice shall be considered a violation of the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act." A violation of section 1111.1 or this section is deemed an unfair method of competition and an unfair deceptive act or practice pursuant to the "Unfair Insurance Practices Act."

(f) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Claim" means a request for payment of benefits under a policy in effect regardless of whether the benefit claimed is covered under the policy or terms or conditions of the policy have been met.

"Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

(1111.2 added July 9, 2010, P.L.362, No.51)

Section 1112. Authority to Promulgate Regulations.--The department shall promulgate reasonable regulations to establish minimum standards for marketing practices, producer compensation arrangements, producer testing, penalties and reporting practices for long-term care insurance.

(1112 amended July 17, 2007, P.L.134, No.40)

Section 1113. Marketing and Advertising Prohibited.--No policy may be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of this article.

(1113 amended July 17, 2007, P.L.134, No.40)

Section 1114. Penalties.--In addition to any other penalties provided by the laws of this Commonwealth, an insurer or producer found to have violated requirements relating to the regulations of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three times the amount of any commissions paid for each policy involved in the violation or ten thousand dollars ($10,000), whichever is greater.

(1114 amended July 17, 2007, P.L.134, No.40)

Section 1115. Applicability.--This article shall apply to all policies delivered or issued for delivery in this Commonwealth on or after the effective date of this article.


ARTICLE XII.
UNIFORM HEALTH INSURANCE CLAIM FORM.

Section 1201. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Department." The Insurance Department of the Commonwealth.

"Health care provider." A person, corporation, facility, institution or other entity licensed, certified or approved by
the Commonwealth to provide health care or professional medical services. The term includes, but is not limited to, a physician, a professional nurse, a certified nurse-midwife, podiatrist, hospital, nursing home, ambulatory surgical center or birth center.

"Insurer." An entity subject to any of the following:
(1) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
(2) This act, including any preferred provider organization subject to section 630.
(4) The act of July 29, 1977 (P.L.105, No.38), known as the "Fraternal Benefit Society Code."
"Supplemental major medical." Any major medical contract which supplements a contract or contracts providing hospitalization and medical surgical benefits.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 1202. Forms for Health Insurance Claims.--(a) Each health insurance claim form processed or otherwise used by an insurer, including those used by the Department of Public Welfare for public health care coverage, shall be the uniform claim form developed by the department. The claim form shall be identical in form and content except as provided in subsection (c). The department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, first consider the feasibility of utilizing the UB-82/HCFA-1450 and HCFA-1500 forms, or their successors, as a uniform claim form. If these forms are deemed to be unsatisfactory, the department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, develop a uniform claim form for use by all insurers, the Department of Public Welfare's public health care coverage program and health care providers. The uniform claim form shall contain blank spaces at appropriate places in the document for approved additional information requests under subsection (c).
(b) The feasibility study and subsequent development of the uniform claim form shall be complete within one hundred eighty (180) days of the effective date of this article. All insurers, the Department of Public Welfare's public health care coverage program and health care providers shall be required to use the uniform claim form within one hundred twenty (120) days after the uniform claim form is developed. The department may consider a request from the Department of Public Welfare for an extension in meeting the implementation schedule of this section.
(c) (1) Subject to the procedure contained in clause (2), an insurer may request that a claimant provide departmentally approved additional information which is not requested on the uniform claim form.
(2) An insurer may request departmental approval of additional information requests to be printed in the blank
spaces on the uniform claim form, and on subsequent pages if necessary, by submitting a written request to the department. Such a request shall be deemed approved by the department if not disapproved within sixty (60) days after receipt of the request. A disapproval shall be subject to the procedures under 2 Pa.C.S. (relating to administrative law and procedure).

(d) In the case of vision and dental claim forms and in the case of supplemental major medical claim forms, utilization of the uniform claim form shall be at the discretion of the individual insurer.


Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 1203. Rules and Regulations.--The department may promulgate rules and regulations to administer and enforce this article.


Section 1204. Penalties.--On satisfactory evidence of a violation of this article by an insurer, the Insurance Commissioner may:

(1) Order that the insurer cease and desist from the violation.

(2) Impose a fine of not more than five hundred dollars ($500) for each violation.


Section 1205. Federal Compliance.--In the event the Federal Government enacts a uniform claim form for mandatory use by all insurers and the Department of Public Welfare's public health care coverage program, the department shall adopt the Federal form for use by all insurers, the Department of Public Welfare's public health care coverage program and health care providers within ninety (90) days of the enactment of the Federal legislation or the effective date included in the Federal act, whichever is later.


Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

ARTICLE XIII.

BROKER CONTROLLED PROPERTY AND CASUALTY INSURERS.

(Art. added Dec. 18, 1992, P.L.1519, No.178)

Section 1301. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Broker." A person, copartnership or corporation, not an officer or agent of the company, association or exchange interested, who or which, for compensation, acts or aids in any manner in obtaining insurance for a person other than himself or itself. An attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney shall not be considered a broker for the purposes of this article.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Control," "controlled" and "controlling." These terms shall have the meaning ascribed in section 1401.

"Department." The Insurance Department of the Commonwealth.
"Independent casualty actuary." A casualty actuary who is a member in good standing of the American Academy of Actuaries and who is not affiliated with, nor an employe, a principal, nor the direct or indirect owner of, or in any way controlled by an insurer or broker.

"Licensed property or casualty insurer" or "insurer." Any person, firm, association or corporation duly licensed to transact a property or casualty insurance business in this Commonwealth. The following, inter alia, are not deemed to be licensed property or casualty insurers for the purposes of this article:

(1) All nonadmitted insurers.
(2) All risk retention groups as defined in the Superfund Amendments and Reauthorization Act of 1986 (Public Law 99-499, 100 Stat. 1613) and Article XV.
(3) All residual market pools and joint underwriting authorities or associations.
(4) All captive insurers, which shall include, but not be limited to, insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks of member organizations or group members and their affiliates.
(5) Licensed foreign insurers domiciled in a state having in effect a law substantially similar to this article.

(Def. amended Feb. 17, 1994, P.L.92, No.9)

"Reinsurance intermediary." Any person, firm, association or corporation which acts as a broker in soliciting, negotiating or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer or acts as a broker in accepting any reinsurance contract or binder on behalf of an assuming insurer.

"Violation." A finding by the Insurance Department of any one or more of the following:

(1) The controlling broker did not materially comply with section 1302.
(2) The controlled insurer, with respect to business placed by the controlling broker, engaged in a pattern of charging premiums that were lower than those being charged by such insurer or other insurers for similar risks written during the same period and placed by noncontrolling brokers. When determining whether premiums were lower than those prevailing in the market, the Insurance Department shall take into consideration applicable industry or actuarial standards at the time the business was written.
(3) The controlling broker failed to maintain records sufficient:
   (i) to demonstrate that such broker's dealings with its controlled insurer were fair and equitable and in compliance with the provisions of Article XIV; and
   (ii) to accurately disclose the nature and details of its transactions with the controlled insurer, including such information as is necessary to support the charges or fees to the respective parties.
(4) The controlled insurer, with respect to business placed by the controlling broker, either failed to establish or deviated from its underwriting procedures.
(5) The controlled insurer's capitalization at the time the business was placed by the controlling broker and with respect to such business was not in compliance with criteria established
by the Insurance Department or otherwise by the insurance laws or regulations of this Commonwealth.

(6) The controlling broker or the controlled insurer failed to substantially comply with the provisions of Article XIV and any rules and regulations relative thereto.

(1301 added Dec. 18, 1992, P.L.1519, No.178)

Section 1302. Limitation on Business Placed with Controlled Insurer.--(a) No broker which has control of a licensed property or casualty insurer may directly or indirectly place business with such insurer in any transaction in which such broker, at the time the business is placed, is acting as such on behalf of the insured for any compensation, commission or other thing of value, unless the requirements of this section are met, including all of the following:

(1) There is a written contract between the controlling broker and the insurer, which contract has been approved by the board of directors of the insurer.

(2) The broker, prior to the effective date of the policy, delivers written notice to the prospective insured disclosing the relationship between that broker and the controlled insurer. This disclosure, signed by the insured, shall be retained in the underwriting file until the filing of the report on the examination covering the period in which the coverage is in effect. If, however, the business is placed through a subbroker who is not a controlling broker, the controlling broker shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has or will notify the insured.

(3) All funds collected for the account of the insurer by the controlling broker are paid, net of commissions, cancellations and other adjustments, to the insurer no less often than quarterly.

(b) In addition to any other required loss reserve certification, the controlled insurer shall annually, on the first day of April of each year, file with the department an opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including incurred but not reported, on business placed by such broker.

(c) The controlled insurer shall annually report to the department the amount of commissions paid to the broker, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling brokers for placements of the same kinds of insurance.

(d) Every controlled insurer shall have an audit committee of the board of directors composed of several directors. Prior to approval of the annual financial statement, the audit committee shall meet with management, the insurer’s independent certified public accountants and an independent casualty actuary to review the adequacy of the insurer's loss reserves.

(e) No reinsurance intermediary which has control of an assuming insurer may directly or indirectly place business with such insurer in any transaction in which such reinsurance intermediary is acting as a broker on behalf of the ceding insurer. No reinsurance intermediary which has control of a ceding insurer may directly or indirectly accept business from such insurer in any transaction in which the reinsurance intermediary is acting as a broker on behalf of the assuming insurer. The prohibitions in this subsection shall not apply to a reinsurance intermediary which makes a full and complete
written disclosure to the parties of its relationship with the assuming or ceding insurer prior to completion of the transaction.

(1302 added Dec. 18, 1992, P.L.1519, No.178)

Section 1302.1. Required Contract Provisions.--Written contracts between controlling brokers and controlled insurers required pursuant to section 1302 must contain the following minimum provisions:

(1) the controlled insurer may terminate the contract for cause, upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination;

(2) the controlling broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by or owing to the controlling broker;

(3) the controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or initial installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under the contract;

(4) all funds collected for the controlled insurer's account shall be held by the controlling broker in a fiduciary capacity in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System in accordance with the provisions of the insurance law as applicable. However, funds of a controlling broker not required to be licensed in this Commonwealth shall be maintained in compliance with the requirements of the controlling broker's domiciliary jurisdiction;

(5) the controlling broker shall maintain separately identifiable records of business written for the controlled insurer;

(6) the contract shall not be assigned in whole or in part by the controlling broker;

(7) the controlled insurer shall provide the controlling broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged and the conditions for the acceptance or rejection of risks. The controlling broker shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a broker other than the controlling broker;

(8) the rates and terms of the controlling broker's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by brokers other than controlling brokers. For purposes of this paragraph and paragraph (7), examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits and similar quality of business;

(9) If the contract provides that the controlling broker, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the
premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection (b) of section 1302;

(10) a limit must be placed on the controlling broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and shall not accept business from the controlling broker if the limit is reached. The controlling broker shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(11) the controlling broker may negotiate but not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer, except that the controlling broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(1302.1 added Feb. 17, 1994, P.L.92, No.9)

Section 1303. Penalties.--(a) If the department has reason to believe that a controlling broker has committed or is committing an act which could be determined to be a violation, as defined in section 1301, it shall serve upon the controlling broker a statement of the charges and notice of a hearing to be conducted in accordance with 2 Pa.C.S. (relating to administrative law and procedure) at a time not less than thirty (30) days after the service of the notice and at a place fixed in the notice.

(b) At this hearing, the department must establish that the controlling broker committed the violation. The controlling broker shall have an opportunity to be heard and to present evidence rebutting the charges. The decision, determination or order of the department shall be subject to judicial review pursuant to 2 Pa.C.S.

(c) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to Article V, and the liquidator or rehabilitator appointed under that order believes that the controlling broker or any other person subject to this article has not materially complied with this article or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the liquidator or rehabilitator may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(1303 added Dec. 18, 1992, P.L.1519, No.178)

Section 1304. Other Penalties Applicable.--Nothing in this article shall affect the right of the department to impose any other penalties provided for in the insurance laws of this Commonwealth.

(1304 added Dec. 18, 1992, P.L.1519, No.178)

Section 1305. Rights of Certain Parties not Affected.--Nothing contained in this article is intended to or shall in any manner alter or affect rights of policyholders, claimants, creditors or other third parties.

(1305 added Dec. 18, 1992, P.L.1519, No.178)
ARTICLE XIV.
INSURANCE HOLDING COMPANIES.
(Art. added Dec. 18, 1992, P.L.1519, No.178)

Section 1401. Definitions.—As used in this article, and for the purposes of this article only, the following words and phrases shall have the meanings given to them in this section:

"Affiliate." A person that directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, the person specified.

"Commissioner." The Insurance Commissioner of the Commonwealth.


"Control," "controlling," "controlled by" and "under common control with." The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten per centum (10%) or more of the votes that all shareholders would be entitled to cast in the election of directors. This presumption may be rebutted by a showing that control does not exist in fact. The Insurance Department may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect or that another person has control. (Def. amended July 5, 2012, P.L.1111, No.136)

"Department." The Insurance Department of the Commonwealth.

"Enterprise risk." An activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, would likely have a material adverse effect on the financial condition or liquidity of an insurer or its insurance holding company system, including, but not limited to, anything that would:

(1) trigger a company action level event for the insurer; or

(2) cause the insurer to be deemed to be in hazardous financial condition under:

(i) Article V of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."

(ii) 31 Pa. Code Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition). (Def. added July 5, 2012, P.L.1111, No.136)

"IAIS." The International Association of Insurance Supervisors or successor organization. (Def. added July 5, 2012, P.L.1111, No.136)

"Insurance holding company system." Two or more affiliated persons, one or more of which is an insurer.

"Insurer." Any health maintenance organization, preferred provider organization, company, association, exchange, hospital plan corporation as defined in and subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation subject to 40 Pa.C.S. Ch. 63
(relating to professional health services plan corporations), authorized by the Insurance Commissioner to transact the business of insurance in this Commonwealth except that the term shall not include:

(1) the Commonwealth or any agency or instrumentality thereof;

(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision; or

(3) fraternal benefit societies.  
(Def. amended July 9, 2008, P.L.885, No.62)

"NAIC." The National Association of Insurance Commissioners or successor organization.  
(Def. amended July 5, 2012, P.L.1111, No.136)

"Person." An individual, an insurer, a corporation, a partnership, a limited liability company, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.  The term shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.  
(Def. amended July 9, 2008, P.L.885, No.62)

"SEC." The Securities and Exchange Commission of the United States.  
(Def. added July 5, 2012, P.L.1111, No.136)

"Security holder." One who owns any security of a specified person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

"Shareholder." A record holder or record owner of shares of an insurer.

(1) The term shall include all of the following:

(i) A member of an insurer that is a domestic nonstock corporation under 15 Pa.C.S. Ch. 21 (relating to nonstock corporations) or a prior statute.

(ii) A member, as defined in 15 Pa.C.S. § 5103 (relating to definitions), of an insurer that is a domestic nonprofit corporation under 15 Pa.C.S. Ch. 51 (relating to general provisions) or a prior statute.

(iii) A subscriber of an insurer that is a domestic reciprocal exchange under Article X or a prior statute.

(2) The term shall not include any subscriber, insured or customer of:

(i) a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(ii) a professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(Def. added July 9, 2008, P.L.885, No.62)

"Subsidiary." An affiliate of a specified person controlled by another person directly or indirectly through one or more intermediaries.

"Voting security." Includes any security convertible into or evidencing a right to acquire a voting security.  
(1401 added Dec. 18, 1992, P.L.1519, No.178)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 1402. Acquisition of Control of or Merger or Consolidation with Domestic Insurer.--(a) (1) No person other
than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would directly or indirectly or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge or consolidate with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request or invitation is made or any such agreement is entered into or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the department and has sent to such insurer a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the department in the manner hereinafter prescribed.

(2) For purposes of this section:
(i) "Domestic insurer" includes a person controlling a domestic insurer unless the department determines that the person is primarily engaged in business other than the business of insurance either directly or through its affiliates.
(ii) "Person" does not include a securities broker who holds, in the usual and customary manner, less than twenty per centum (20%) of the voting securities of an insurer or of a person that controls an insurer.

((2) amended July 5, 2012, P.L.1111, No.136)

(3) A controlling person of a domestic insurer seeking to divest its controlling interest in the insurer in any manner shall file with the department, with a copy to the insurer, a notice of the proposed divestiture at least thirty (30) days prior to the cessation of control except that notice under this paragraph is not required if a statement is filed under paragraph (1). The notice must contain information sufficient for the department to determine if the proposed divestiture requires filing and approval under paragraph (1). Information obtained by or disclosed to the department under this paragraph shall be given confidential treatment as provided under section 1407. ((3) added July 5, 2012, P.L.1111, No.136)

(4) The acquiring person for transactions subject to this section must file a preacquisition notification as required under section 1403(c) or be subject to a penalty as provided under section 1403(e)(3). ((4) added July 5, 2012, P.L.1111, No.136)

(5) A person seeking to rebut the presumption of control under this article shall file with the department, with a copy to the insurer, a rebuttal filing containing information sufficient for the department to determine whether control exists in fact. The filing is not effective unless the department finds that control does not exist or accepts a disclaimer of control. Information obtained by or disclosed to the department under this subsection must be given confidential treatment as provided under section 1407. ((5) added July 5, 2012, P.L.1111, No.136)

(b) The statement to be filed with the department under this section shall be made under oath or affirmation and shall contain the following information:
(1) The name and address of each person by whom or on whose behalf the merger, consolidation or other acquisition of control referred to in subsection (a) is to be effected, hereinafter called "acquiring party," and
(i) if such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years; or

(ii) if such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to those positions. This list shall include for each individual the information required by subparagraph (i).

(2) The source, nature and amount of the consideration used or to be used in effecting the merger, consolidation or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in subsection (a) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a), and a statement as to the method by which the fairness of the proposal was arrived.

(6) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(8) A description of the purchase of any security referred to in subsection (a) during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve
calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (a) and, if distributed, of additional soliciting material relating thereto.

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(11.1) An agreement by the person required to file the statement referred to in subsection (a) that it will provide the annual enterprise risk report specified in section 1404(k.1) as long as control exists. ((11.1) added July 5, 2012, P.L.1111, No.136)

(11.2) An acknowledgment by the person required to file the statement referred to in subsection (a) that the person and the subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer. ((11.2) added July 5, 2012, P.L.1111, No.136)

(12) Such additional information as the department may by regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest. ((12) amended July 5, 2012, P.L.1111, No.136)

(c) If the person required to file the statement referred to in subsection (a) is a partnership, limited partnership, syndicate or other group, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection (a) is a corporation, the department may require that the information called for by subsection (b)(1) through (12) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten per centum (10%) of the outstanding voting securities of such corporation.

(d) If any material change occurs in the facts set forth in the statement filed with the department and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the department and sent to such insurer within two (2) business days after the person learns of such change.

(e) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) is proposed to be made by means of a registration statement under the Securities Act of 1933 (48 Stat. 74, 15 U.S.C. § 77a et seq.), or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 (48 Stat. 881, 15 U.S.C. § 78a et seq.), or under a State law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) may utilize such documents in furnishing the information called for by that statement.
(f) (1) The department shall approve any merger, consolidation or other acquisition of control referred to in subsection (a) unless it finds any of the following:

(i) After the merger, consolidation or other acquisition of control, the domestic insurer referred to in subsection (a) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(ii) The effect of the merger, consolidation or other acquisition of control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:

(A) the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;

(B) the merger, consolidation or other acquisition of control shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and

(C) the department may condition the approval of the merger, consolidation or other acquisition of control on the removal of the basis of disapproval within a specified period of time.

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable and fail to confer benefit on policyholders of the insurer and are not in the public interest.

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger, consolidation or other acquisition of control.

(vi) The merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public.

(vii) The merger, consolidation or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A.

(2) If the merger, consolidation or other acquisition of control is approved, the department shall so notify the person filing the statement and the insurer that is proposed to be acquired, and such a determination is hereafter referred to as an approving determination. Notice shall also be given by the department of any determination which is not an approving determination. If an approving determination is made by the department and not otherwise, the proposed offer and acquisition may thereafter be made and consummated on the terms and conditions and in the manner described in the statement and subject to such conditions as may be prescribed by the department as hereinafter provided. An approving determination by the department shall be deemed to extend to offers or acquisitions made pursuant thereto within one year following the date of determination. The department may, as a condition of its approving determination, require the inclusion in any offer of provisions requiring the offer to remain open a specified minimum length of time, permitting withdrawal of shares deposited prior to the time the offeror becomes bound to consummate the acquisition and requiring pro rata acceptance
of any shares deposited pursuant to the offer. The department shall hold a hearing before making the determination required by this subsection if, within ten (10) days following the filing with the department of the statement, written request for the holding of such hearing is made either by the person proposing to make the acquisition, by the insurer that is proposed to be acquired or, if the issuer of stock proposed to be acquired is not an insurer, by the insurer controlled by such issuer. Otherwise, the department shall determine in its discretion whether such a hearing shall be held. Thirty (30) days' notice of any such hearing shall be given to the person proposing to make the acquisition, to the issuer whose stock is proposed to be acquired and, if such issuer is not an insurer, to the insurance company controlled by such issuer. Notice of any such hearing shall also be given to such other persons, if any, as the department may determine.

(2.1) If the proposed acquisition of control requires the approval of more than one chief insurance regulatory official, the public hearing under paragraph (2) may be held on a consolidated basis upon request of the person filing the statement under subsection (a). He shall file the statement under subsection (a) with the NAIC within five (5) days of making the request for a public hearing. A chief insurance regulatory official may opt out of a consolidated hearing and shall provide notice to the applicant of the decision to opt out within ten (10) days of the receipt of the statement under subsection (a). A hearing conducted on a consolidated basis must be public and held in the United States before the chief insurance regulatory officials of the states in which the insurers are domiciled. The chief insurance regulatory officials shall hear and receive evidence. A chief insurance regulatory official may attend the hearing in person or participate using telecommunication. ((2.1) added July 5, 2012, P.L.1111, No.136)

(3) The department may retain at the acquiring party's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the proposed acquisition of control. ((3) amended July 5, 2012, P.L.1111, No.136)

(g) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the department by order shall exempt therefrom as:
(1) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or
(2) as otherwise not comprehended within the purposes of this section.

(h) The following shall constitute a violation of this section:
(1) the failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b);
(2) the effectuation or any attempt to effectuate an acquisition of control of or divestiture of or merger or consolidation with a domestic insurer unless the department has given its approval thereto; or
(3) a violation of section 819-A.
((h) amended July 5, 2012, P.L.1111, No.136)

(i) The department shall, within seventy-two (72) hours of receiving a statement filed under this section, provide notification to the Office of Attorney General that the filing was received.
Section 1403. Acquisitions Involving Insurers not Otherwise Covered.--(a) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Acquisition." Any agreement, arrangement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of another person and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance, mergers and consolidations.

"Involved insurer." Includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger or consolidation.

(b) (1) Except as exempted in paragraph (2), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this Commonwealth.

(2) This section shall not apply to any of the following:

(i) An acquisition subject to approval or disapproval by the department pursuant to section 1402.

(ii) A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this Commonwealth. If a purchase of securities results in a presumption of control as described in the definition of "control" in section 1401, it is not solely for investment purposes unless the chief insurance regulatory official in the jurisdiction of the insurer's domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary insurance regulator to the department.

(iii) The acquisition of already affiliated persons.

(iv) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the department in accordance with subsection (c)(2) thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by this paragraph.

(v) An acquisition if, as an immediate result of the acquisition:
(A) in no market would the combined market share of the involved insurers exceed five per centum (5%) of the total market;
(B) there would be no increase in any market share; or
(C) in no market would:
(I) the combined market share of the involved insurers exceeds twelve per centum (12%) of the total market; and
(II) the market share increases by more than two per centum (2%) of the total market.

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

(vi) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business.

(vii) An acquisition of an insurer whose domiciliary insurance regulator affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary insurance regulator to the department. ((vii) amended July 5, 2012, P.L.1111, No.136)

(3) Sections 1409(b) and (c) and 1411 shall not apply to acquisitions provided for in this subsection.

((b) amended July 9, 2008, P.L.885, No.62)

(c) (1) An acquisition covered by subsection (b) may be subject to an order pursuant to subsection (e) unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The department shall give confidential treatment to information submitted under this subsection in the same manner provided in section 1407.

(2) The preacquisition notification shall be in such form and contain such information as prescribed by the NAIC relating to those markets which, under subsection (b)(2)(v), cause the acquisition not to be exempted from the provisions of this section. The department may require such additional material and information as it deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (d). The required information may include an opinion of an economist as to the competitive impact of the acquisition in this Commonwealth accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(3) The waiting period required shall begin on the date of receipt by the department of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of such receipt or termination of the waiting period by the department. Prior to the end of the waiting period, the department on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of such additional information by the department or termination of the waiting period by the department.

(d) (1) The department may enter an order under subsection (e)(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this
Commonwealth or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c).

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1), the department shall consider the following:

(i) Any acquisition covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards as follows:

(A) if the market is highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer A</th>
<th>Insurer B</th>
</tr>
</thead>
<tbody>
<tr>
<td>4% or more</td>
<td>4% or more</td>
</tr>
<tr>
<td>10%</td>
<td>2% or more</td>
</tr>
<tr>
<td>15%</td>
<td>1% or more; or</td>
</tr>
</tbody>
</table>

(B) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer A</th>
<th>Insurer B</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% or more</td>
<td>5% or more</td>
</tr>
<tr>
<td>10%</td>
<td>4% or more</td>
</tr>
<tr>
<td>15%</td>
<td>3% or more</td>
</tr>
<tr>
<td>19%</td>
<td>1% or more</td>
</tr>
</tbody>
</table>

A highly concentrated market is one in which the share of the four largest insurers is seventy-five per centum (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph (1). For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per centum (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition, merger or consolidation covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (1) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(C) another involved insurer's market is two per centum (2%) or more.

(iii) For the purposes of this paragraph:

(A) The term "insurer" includes any company or group of companies under common management, ownership or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the department shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in
this Commonwealth and the relevant geographical market is assumed to be this Commonwealth.

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the competitive standard under subparagraphs (i) and (ii), the department may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (i) and (ii), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(3) An order may not be entered under subsection (e)(1) if:

(i) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(ii) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

((d) amended July 9, 2008, P.L.885, No.62)

(e) (1) (i) If an acquisition violates the standards of this section, the department may enter an order:

(A) requiring an involved insurer to cease and desist from doing business in this Commonwealth with respect to the line or lines of insurance involved in the violation; or

(B) denying the application of an acquired or acquiring insurer for a license to do business in this Commonwealth.

(ii) Such an order shall be issued in compliance with 2 Pa.C.S. (relating to administrative law and procedure).

(iii) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the department under paragraph (1) and while such order is in effect, may, after notice and hearing and upon order of the department, be subject at the discretion of the department to either or both of the following:

(i) A civil penalty of not more than ten thousand dollars ($10,000) for every day of violation.

(ii) Suspension or revocation of such person's license.

(3) Any insurer or other person who fails to make any filing required by this section and who also fails to demonstrate a good faith effort to comply with any such filing requirement shall be subject to a civil penalty not to exceed fifty thousand dollars ($50,000).

(1403 added Dec. 18, 1992, P.L.1519, No.178)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 1403.1. Committee Review.--(a) The Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives may review an application or statement submitted by a hospital plan corporation or
professional health services plan corporation seeking the
approval of a merger, consolidation or other acquisition of
control of a hospital plan corporation or professional health
services plan corporation under this act.

(b) The Banking and Insurance Committee of the Senate and
the Insurance Committee of the House of Representatives shall
have the following powers and duties:

(1) To convene the committee for purposes of reviewing an
application for approval of a merger, consolidation or other
acquisition of control under this section.

(2) To receive and review all filings submitted to the
department relating to the merger, consolidation or other
acquisition of control and all accompanying data and other
information. This paragraph shall not apply to information
deemed confidential or proprietary by the department.

(3) To consult experts, hold hearings and obtain additional
information relating to the merger, consolidation or other
acquisition of control.

(4) To develop written comments and recommendations on the
merger, consolidation or acquisition of control and submit them
to the department within forty-five (45) days of the close of
the public comment period established under this paragraph,
developed by the department on the merger, consolidation or
other acquisition of control. The department shall publish the
date of the close of the public comment period in the
Pennsylvania Bulletin prior to final closure of the public
comment period. The department may issue a final order and
determination on or after one hundred five (105) days following
the public comment period.

(c) The commissioner, the department and its attorneys and
experts, including experts employed or retained by the
department, shall be available to provide testimony to each
committee relating to the merger, consolidation or other
acquisition of control. Nothing in this act shall affect any
privileges or immunities of the department or its attorneys,
experts or consultants. The department or its attorneys, experts
or consultants shall not be required to appear before either
committee within thirty (30) days following the department's
issuance of a final order and determination.

(d) The department shall provide a detailed written response
to each comment and recommendation submitted by the Banking and
Insurance Committee of the Senate or the Insurance Committee
of the House of Representatives in its final order. The order
and determination shall not be issued before sixty (60) days
have elapsed following receipt of the comments and
recommendations under subsection (b)(4).

(e) If no comments and recommendations are received under
subsection (b)(4), the department may issue a final order and
determination on or after one hundred five (105) days following
the close of the public comment period.

(1403.1 added July 9, 2008, P.L.885, No.62)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008
in the appendix of this act for special provisions
relating to mergers, consolidations or other acquisitions
of control.

Section 1403.2. Insurance Restructuring Restricted Receipt
Account.--(a) There is established in the State Treasury a
restricted receipt account to be known as the Insurance
Restructuring Restricted Receipt Account. Interest earned on
money in the account shall be deposited into the account.
(b) All net economic benefits, including proceeds, savings, funds or moneys derived from and any agreement related to or from the merger, consolidation or other acquisition of control of a hospital plan corporation or professional health services plan corporation which are to be paid to the Commonwealth or a Commonwealth program shall be deposited into the account for purposes as determined by the General Assembly.

(c) No contract or written agreement between a hospital plan corporation or professional health services plan corporation and the Commonwealth or any other entity relating to the disbursement or spending of money in the account may be entered into until moneys that may exist or are to be derived from any contract or written agreement for deposit into the account are appropriated by the General Assembly.

(d) No moneys or funds may be transferred or paid from the account unless appropriated by the General Assembly.

(1403.2 added July 9, 2008, P.L.885, No.62)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 1404. Registration of Insurers.--(a) (1) Every insurer which is authorized to do business in this Commonwealth and which is a member of an insurance holding company system shall register with the department, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section and section 1405(a)(1) and (2), (b) and (d). Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each such change or addition.

(2) Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by the thirty-first day of March of each year for the previous calendar year, unless the department for good cause shown extends the time for registration, and then within such extended time. The department may require any insurer authorized to do business in this Commonwealth which is a member of an insurance holding company system and which is not subject to registration under this section to furnish a copy of the registration statement, the summary specified in subsection (c) or other information filed by such insurance company with the insurance regulatory authority of its domiciliary jurisdiction. ((2) amended July 5, 2012, P.L.1111, No.136)

(b) Every insurer subject to registration shall file the registration statement with the department on a form and in a format prescribed by the NAIC, which shall contain all of the following current information: (Intro. par. amended July 5, 2012, P.L.1111, No.136)

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer.

(2) The identity and relationship of every member of the insurance holding company system.

(3) All of the following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between such insurer and its affiliates:
(i) Loans and other investments and the purchase, sale or exchange of securities of an affiliate by the insurer or of the insurer by an affiliate.

(ii) Purchases, sales or exchange of assets.

(iii) Transactions not in the ordinary course of business.

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

(v) All management agreements, service contracts and all cost-sharing arrangements.

(vi) Reinsurance agreements.

(vii) Dividends and other distributions to shareholders.

(viii) Consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(4.1) If requested by the department, the insurer shall include financial statements of an insurance holding company system, including its affiliates. Financial statements may include, but are not limited to:

(i) annual audited financial statements filed with the SEC under the Securities Exchange Act of 1933 (48 Stat. 74, 15 U.S.C. § 77a et seq.); or


An insurer required to file financial statements under this paragraph may satisfy the request by providing the department with the most recent parent corporation financial statements filed with the SEC.

((4.1) added July 5, 2012, P.L.1111, No.136)

(4.2) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures. ((4.2) added July 5, 2012, P.L.1111, No.136)

(5) Any other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the department.

(6) Other necessary or appropriate information as required by the department by regulation. ((6) added July 5, 2012, P.L.1111, No.136)

(c) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) No information need be disclosed on the registration statement filed pursuant to subsection (b) if such information is not material for the purposes of this section. Unless the department by regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one per centum (0.5%) or less of an insurer's admitted assets as of the thirty-first day of December next preceding shall not be deemed material for purposes of this section. ((d) amended July 5, 2012, P.L.1111, No.136)

(e) Subject to section 1405(b), each registered insurer shall report to the department all dividends and other distributions to shareholders within five (5) business days following the declaration thereof and at least ten (10) days, commencing from the date of receipt by the department, prior
to payment thereof. The report shall include a schedule setting forth all dividends or other distributions made within the previous twelve (12) months, including any dividends or other distributions approved by the department to be paid out of other than unassigned surplus pursuant to section 337.8. ((e) amended Feb. 17, 1994, P.L.92, No.9)

(f) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this article.

(g) The department shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(h) The department may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement.

(i) The department may allow an insurer which is authorized to do business in this Commonwealth and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the department by regulation or order shall exempt the same from the provisions of this section. ((j) amended July 5, 2012, P.L.1111, No.136)

(k) Any person may file with the department a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation is deemed granted unless the department notifies the filing party the disclaimer is disallowed within thirty (30) days following receipt of a complete disclaimer. In the event of disallowance, the disclaiming party may request an administrative hearing under the provisions of 2 Pa.C.S. (relating to administrative law and procedure), which must be granted. If the commissioner approves the disclaimer or if the disclaimer is deemed approved, the disclaiming party is relieved of the duty to register under this section. ((k) amended July 5, 2012, P.L.1111, No.136)

(k.1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report must, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report must be filed with the lead state regulator of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC. Beginning in 2014, and every year thereafter, the report shall be filed by March 31 for the previous calendar year. ((k.1) added July 5, 2012, P.L.1111, No.136)

(l) The failure to file a registration statement, any summary of the registration statement or enterprise risk report required by this section within the time specified for such filing shall be a violation of this section. ((l) amended July 5, 2012, P.L.1111, No.136)

(1404 added Dec. 18, 1992, P.L.1519, No.178)
Section 1405. Standards and Management of an Insurer within an Insurance Holding Company System.--(Hdg. amended July 5, 2012, P.L.1111, No.136) (a) (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to all of the following standards:

(i) The terms shall be fair and reasonable.
(ii) Charges or fees for services performed shall be reasonable.
(iii) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied and all cost-sharing or expense allocation arrangements must be formalized in writing and authorized by the board of directors of the domestic insurer.
(iv) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.
(v) The insurer's surplus as regards policyholders after any material transaction with an affiliate and after any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including an amendment or modification of affiliate agreements previously filed under this section that are subject to materiality standards contained in subparagraphs (i), (ii), (iii), (iv) and (v), may not be entered into unless the insurer has notified the department in writing of its intention to enter into such transaction at least thirty (30) days prior thereto or such shorter period as the department may permit and the department has not disapproved it within such period:

(i) Sales, purchases, exchanges, loans or extensions of credit, guarantees, investments, pledges of assets or assets to be received by the domestic insurer as contributions to its surplus, provided that, as of the thirty-first day of December next preceding, such transactions are equal to or exceed the lesser of three per centum (3%) of the insurer's admitted assets or twenty-five per centum (25%) of surplus as regards policyholders.
(ii) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of or to make investments in any affiliate of the insurer making such loans or extensions of credit provided that, as of the thirty-first day of December next preceding, such transactions are equal to or exceed the lesser of three per centum (3%) of the insurer's admitted assets or twenty-five per centum (25%) of surplus as regards policyholders.
(iii) Reinsurance agreements or modifications thereto, including:

(A) agreements where the reinsurance premium or the projected reinsurance premium in any of the next three twelve-month periods equals or exceeds five per centum (5%) of
the insurer's surplus as regards policyholders as of the thirty-first day of December next preceding;

(B) agreements where the change in the insurer's liabilities or any transfer of assets required to fund the transaction in any of the next three twelve-month periods equals or exceeds twenty-five per centum (25%) of the insurer's surplus as regards policyholders as of the thirty-first day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer. Nothing in this paragraph shall affect or limit the requirements and applicability of section 3 of the act of July 31, 1968 (P.L.941, No.288), entitled "An act providing for reporting to the Insurance Commissioner by domestic insurance companies, associations, or exchanges, of certain conveyances of interests in the assets of such companies, associations, or exchanges"; or

(C) reinsurance pooling agreements.

(iv) Any material transactions, specified by regulation, which the department determines may adversely affect the interests of the insurer's policyholders.

(v) Management agreements, service contracts, tax allocation agreements, guarantees and cost-sharing arrangements. The notice for amendments or modifications must include the reasons for the change and the financial impact on the domestic insurer. Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law.

((2) amended July 5, 2012, P.L.1111, No.136)

(2.1) Within thirty (30) days after termination of an agreement previously filed in accordance with paragraph (2), a domestic insurer shall provide notice of the termination to the department. ((2.1) added July 5, 2012, P.L.1111, No.136)

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the department determines that such separate transactions were entered into over any twelve-month period for such purpose, it may exercise its authority under section 1410. ((3) amended July 5, 2012, P.L.1111, No.136)

(4) The department, in reviewing transactions pursuant to paragraph (2), shall consider whether the transactions comply with the standards set forth in paragraph (1) and whether they may adversely affect the interests of policyholders. The department may retain at the insurer's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the transaction.

(5) The department shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in such corporation by the insurance holding company system exceeds ten per centum (10%) of such corporations' voting securities.

(b) (1) No domestic insurer shall pay any extraordinary dividend to its shareholders until:
(i) thirty (30) days after the commissioner has received written notice from the insurer of the declaration of the dividend and has not within such period disapproved the payment; or
(ii) the commissioner shall have approved the payment within such thirty-day period.

((1) amended July 5, 2012, P.L.1111, No.136)

(2) For purposes of this subsection, an extraordinary dividend is any dividend or other distribution which, together with other dividends and distributions made within the preceding twelve (12) months, exceeds the greater of:
(i) ten per centum (10%) of such insurer's surplus as regards policyholders as shown on its last annual statement on file with the commissioner; or
(ii) the net income of such insurer for the period covered by such statement, but shall not include pro rata distributions of any class of the insurer's own securities.

(c) (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this article.

(2) Nothing herein shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of subsection (a)(1).

(3) (i) Not less than one-third of the directors of a domestic insurer shall be persons who are not officers or employes of such insurer or of any entity controlling, controlled by or under common control with such insurer and who are not beneficial owners of a controlling interest in the voting stock of such insurer or any such entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors.

(ii) Not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employes of such insurer or of any entity controlling, controlled by or under common control with such insurer. At least one such person must be included in any quorum for the transaction of business at any meeting of each committee.

(4) The board of directors of a domestic insurer shall establish a committee comprised solely of directors who are not officers or employes of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee shall have responsibility for recommending the selection of independent certified public accountants and reviewing the insurer's financial condition, the scope and results of the independent audit and any internal audit. The committee may also have the responsibilities described in paragraph (4.1) if one or more committees described in paragraph (4.1) are not separately established.

(4.1) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employes of the insurer or of any entity controlling, controlled by or under common control with the insurer. The committee or committees shall have responsibility for recommending candidates to be nominated by the board of
directors, in addition to any other nominations by voting shareholders or policyholders, for election as directors by voting shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of paragraphs (3), (4) and (4.1) shall not apply to a domestic insurer if the person controlling such insurer is an insurer, an attorney in fact for a reciprocal exchange, a mutual insurance holding company or a publicly held corporation having a board of directors and committees thereof which already meet the requirements of paragraphs (3), (4) and (4.1). ((5) amended July 5, 2012, P.L.1111, No.136)

(c) amended July 9, 2008, P.L.885, No.62)

(d) For purposes of this article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several lines of insurance.

(3) The number and size of risks insured in each line of business.

(4) The extent of the geographical dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification and liquidity of the insurer's investment portfolio.

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

(8) The surplus as regards policyholders maintained by other comparable insurers considering the factors set forth in paragraphs (1) through (7).

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in affiliates. The department may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in its judgment such investment so warrants.

(11) The quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items.

(1405 amended Feb. 17, 1994, P.L.92, No.9)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 1406. Examination.--(a) Subject to the limitation contained in this section and in addition to the powers which the department has under law relating to the examination of insurers, the department shall also have the power to examine an insurer registered under section 1404 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by:

(1) the ultimate controlling person;

(2) an entity or combination of entities within the insurance holding company system; or
(3) the insurance holding company system on a consolidated basis.

(a.1) The department may order an insurer registered under section 1404 to produce records, books or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to ascertain the financial condition of the insurer or to determine compliance with this article.

(a.2) To ascertain the financial condition of the insurer, including the enterprise risk to the insurer by:

(1) the ultimate controlling person;

(2) an entity or combination of entities within the insurance holding company system; or

(3) the insurance holding company system on a consolidated basis,

the department may order an insurer registered under section 1404 to produce information not in the possession of the insurer if the insurer can obtain access to the information under a contractual relationship, a statutory obligation or other method. If the insurer may not obtain the information requested by the department, the insurer shall provide the department a detailed explanation of the reason the insurer may not obtain the information and the identity of the holder of information. If the insurer fails to comply with this subsection or the department determines that the detailed explanation is without merit, the department may suspend or revoke the insurer's license or require the insurer to pay an administrative penalty of one thousand dollars ($1,000) per day until the information is produced. The proceeding for suspension, revocation or imposition of a penalty shall be conducted pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

(b) The department may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as shall be reasonably necessary to assist in the conduct of the examination under subsections (a), (a.1) and (a.2). Any persons so retained shall be under the direction and control of the department and shall act in a purely advisory capacity.

(c) Each registered insurer producing for examination records, books and papers pursuant to subsections (a), (a.1) and (a.2) shall be liable for and shall pay the expense of such examination as provided for in Article IX of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one."

(d) If the insurer fails to comply with an order issued under this section, the department has the power to examine the insurer's affiliates to obtain the information necessary to determine an insurer's compliance with this section. The department also has the power to:

(1) issue subpoenas;

(2) administer oaths; and

(3) examine under oath any person as to any matter pertinent to determining compliance with this section.

Upon the failure or refusal of a person to obey a subpoena, the department may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. When subpoenaed, a person shall attend as a witness at the place specified in the subpoena. Witnesses shall be paid the same fees and mileage as are paid to witnesses in the courts of this Commonwealth. Fees, mileage and expense necessarily incurred in securing the attendance and testimony
of witnesses shall be itemized, charged against and paid by the
person being examined.
(1406 amended July 5, 2012, P.L.1111, No.136)

Section 1406.1. Supervisory Colleges.--(a) A supervisory
college may be convened as a temporary or permanent forum for
communication and cooperation between the regulators charged
with the supervision of the insurer or its affiliates.
(b) The department may participate in a supervisory college
with other regulators charged with supervision of the insurer
or its affiliates, including international, Federal and other
state regulatory agencies, for any of the following reasons:
(1) To assess the enterprise risk, business strategy, legal,
regulatory and financial position, risk exposure, risk
management and governance processes of the insurer or its
affiliates.
(2) As part of the examination of individual insurers in
accordance with section 1406.
(c) The department shall have the power to participate in
a supervisory college for a domestic insurer, registered under
section 1404, that is part of an insurance holding company
system with international operations in order to determine
compliance by the insurer with this article.
(d) The powers of the department regarding supervisory
colleges include, but are not limited to, the following:
(1) Initiating the establishment of a supervisory college.
(2) Clarifying the membership and participation of other
supervisors in the supervisory college.
(3) Clarifying the functions of the supervisory college and
the role of other regulators, including the establishment of a
group supervisor.
(4) Coordinating the ongoing activities of the supervisory
college, including planning meetings, supervisory activities
and processes for information sharing.
(5) Establishing a crisis management plan.
(e) The department may enter into agreements in accordance
with sections 1406.2, 1407 and Article II-A of the act of May
17, 1921 (P.L.789, No.285), known as "The Insurance Department
Act of 1921," to provide the basis for sharing information
between the department and other regulatory agencies. The
department may also enter into agreements to share information
and further coordinate the activities of the supervisory college
pursuant to this section. Nothing in this section shall delegate
to the supervisory college the authority of the department to
regulate or supervise the insurer or its affiliates within its
jurisdiction.
(f) A registered insurer subject to this section shall be
liable for and shall pay the reasonable expenses of the
department's participation in a supervisory college, including
reasonable travel expenses.
(1406.1 added July 5, 2012, P.L.1111, No.136)

Section 1406.2. Group-wide Supervision for International
Insurance Groups.--(a) (Reserved).
(b) The department is authorized to act as the group-wide
supervisor for any international insurance group where the
international insurance group's ultimate controlling person is
domiciled in Pennsylvania. However, the department may otherwise
acknowledge another jurisdiction as the group-wide supervisor
where the international insurance group:
(1) Does not have substantial insurance operations in the
United States.
(2) Has substantial insurance operations in the United
States, but not in Pennsylvania.
(3) Has substantial insurance operations in the United States and Pennsylvania, but the department has determined pursuant to the factors set forth in subsections (c)(1), (2), (3), (4), (5), (6) and (7) and (f) that the other jurisdiction is the appropriate group supervisor.

(c) In cooperation with other supervisors, the department may determine that it is the appropriate group-wide supervisor for an international insurance group with substantial operations concentrated in Pennsylvania or in insurance operations conducted by subsidiary insurance companies domiciled in Pennsylvania, where the ultimate controlling person is domiciled outside Pennsylvania, or it may acknowledge that another chief insurance regulatory official is the appropriate group-wide supervisor for the international insurance group. The department shall consider the following factors and the relative scale of each when making a determination or acknowledgment under this subsection:

(1) The location where the international insurance group is based or the place of domicile of the ultimate controlling person of the international insurance group.

(2) The locations of the international insurance group's executive offices.

(3) The locations of origin of the insurance business of the international insurance group.

(4) The locations of the assets and liabilities of the international insurance group.

(5) The locations of the business operations and activities of the international insurance group.

(6) Whether another chief insurance regulatory official is acting or seeking to act as the lead group-wide supervisor under a regulatory system that the department determines to be:

(i) substantially similar to that provided under the laws of this Commonwealth; or

(ii) otherwise sufficient in terms of provision of group-wide supervision, enterprise risk analysis and cooperation with other chief regulatory officials.

(7) Whether a chief insurance regulatory official acting or seeking to act as the lead group-wide supervisor provides the department with reasonably reciprocal recognition and cooperation.

(d) Pursuant to section 1406, the department is authorized to collect from any insurer registered pursuant to section 1404 all information necessary to determine whether the department may act as the group-wide supervisor or if the department may acknowledge another insurance regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an international insurance group is subject to group-wide supervision by the department, the department shall notify the insurer registered pursuant to section 1404 and the ultimate controlling person within the international insurance group. The international insurance group shall have not less than thirty (30) days to provide the department with additional information pertinent to the pending determination. The department shall publish in the Pennsylvania Bulletin and on its Internet website the identity of international insurance groups that it has determined are subject to its group-wide supervision.

(e) If the department is the group-wide supervisor for an international insurance group, the department is authorized to engage in conducting and coordinating any of the following group-wide supervision activities:
(1) Assess the enterprise risks within the international insurance group, pursuant to section 1406, to ensure that:
   (i) The material financial condition and liquidity risks to the members of the international insurance group which are engaged in the business of insurance are identified by management.
   (ii) Reasonable and effective mitigation measures are in place.
(2) Request, from any member of an international insurance group subject to the department's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the international insurance group regarding:
   (i) Governance, risk assessment and management.
   (ii) Capital adequacy.
   (iii) Material intercompany transactions.
(3) Compel development and implementation of reasonable measures designed to assure that the international insurance group is able to timely recognize and mitigate material risks to members that are engaged in the business of insurance.
(4) Communicate with other insurance regulatory officials for members within the international insurance group and share relevant information subject to the confidentiality provisions of section 1407, through supervisory colleges as set forth in section 1406.1 or otherwise.
(5) Enter into agreements with or obtain documentation from any insurer registered under section 1404, any member of the international insurance group and any other chief insurance regulatory officials for members, providing the basis for or otherwise clarifying the department's role as group supervisor, including provisions for resolving disputes with other relevant supervisory authorities. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not incorporated in this Commonwealth is doing business in this Commonwealth or is otherwise subject to jurisdiction in this Commonwealth.
(6) Other group-wide supervisory activities as considered appropriate by the department.
   (f) If the department acknowledges that a regulatory official from a jurisdiction which is not accredited by the NAIC is the group-wide supervisor, the department is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group supervision undertaken by the group-wide supervisor, provided that:
      (1) The department's cooperation is in compliance with the laws of this Commonwealth.
      (2) The regulator also recognizes and cooperates with the department's activities as a group-wide supervisor for other international insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the department is authorized to refuse recognition and cooperation.
   (g) The department is authorized to enter into agreements with or obtain documentation from any insurer registered under section 1404, any affiliate of the insurer and other regulatory officials for members of the insurance group, which provide the basis for or otherwise clarify a regulatory official's role as group supervisor.
   (h) The department may promulgate regulations necessary for the administration of this section. In determining whether a regulation should be promulgated, the department shall give due consideration to model laws, model regulations and definitions
or guidelines pertaining to group-wide supervision, if any, promulgated by the NAIC or other recognized insurance regulatory bodies or associations.

(i) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the department's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

(j) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Group-wide supervisor." The chief insurance regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is from the jurisdiction determined or acknowledged by the department under subsection (c) to have sufficient significant contacts with the international insurance group.

"International insurance group." An insurance group operating internationally that includes an insurer registered under section 1404.

(1406.2 added July 5, 2012, P.L.1111, No.136)

Section 1407. Confidential Treatment.--(a) All information, documents, materials and copies thereof in the possession or control of the department that are produced by, obtained by or disclosed to the department or any other person in the course of an examination or investigation made pursuant to section 1406 or investigation made pursuant to section 1406.1 or 1406.2 and all information reported pursuant to sections 1402(b)(11.1) and (11.2), 1404 and 1405 shall be privileged and given confidential treatment and shall not be:

(1) Subject to discovery or admissible in evidence in a private civil action.

(2) Subject to subpoena.

(3) Subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(4) Made public by the department or any other person, except to regulatory or law enforcement officials of other jurisdictions or group supervisors or members of a supervisory college in accordance with subsection (c), without the prior written consent of the insurer to which it pertains unless the department, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event it may publish all or any part thereof in such manner as it may deem appropriate.

(b) The commissioner, department or any individual or person who receives documents, materials or other information while acting under the authority of the commissioner or department or with whom such documents, materials or other information are shared under this article shall not be permitted or required to testify in any private civil action concerning any confidential documents, materials or information covered under this section.

(c) In order to assist in the performance of its duties, the department may do any of the following:

(1) Share confidential and privileged documents, materials or other information covered under this section with regulatory or law enforcement officials of this Commonwealth or other jurisdictions, the IAIS, the NAIC and its affiliates and subsidiaries, group supervisors and members of any supervisory
college under section 1406.1, provided that prior to receiving the documents, materials or other information, the recipient demonstrates by written statement the necessary authority and intent to provide the same confidential treatment to the information as required by this article. The department may only share confidential and privileged documents, materials or information reported under section 1404(k.1) with state insurance regulators having statutes or regulations substantially similar to subsection (a) and who have agreed in writing not to disclose such information.

(2) Receive and maintain as confidential any documents, materials or other information from the IAIS or the NAIC and its affiliates and subsidiaries or from regulatory and law enforcement officials of this Commonwealth or other jurisdictions in which the documents, materials or other information are confidential by law in those jurisdictions. Documents, materials or other information obtained under this section shall be given confidential treatment, may not be subject to subpoena and may not be made public by the department, commissioner or any other person.

(d) The department shall enter into written agreements with the IAIS or the NAIC governing the sharing and use of information provided under this article, that include all of the following:

(1) Specific procedures and protocols regarding the confidentiality and security of information shared with the IAIS or the NAIC and its affiliates and subsidiaries under this article, including procedures and protocols for sharing by the IAIS or the NAIC with other Federal, state or international regulators.

(2) Provisions specifying that ownership of information shared with the IAIS or the NAIC and its affiliates and subsidiaries under this article remains with the department and that the use of the information by the IAIS or the NAIC is subject to the approval of the department.

(3) A provision providing that the IAIS or the NAIC and its affiliates and subsidiaries will, where permitted by law, give prompt notice to the department and the insurer regarding any subpoena, request for disclosure or request for production of the insurer's confidential information in the possession of the IAIS or the NAIC under this article.

(4) A requirement that the IAIS or the NAIC and its affiliates and subsidiaries will consent to intervention by an insurer in any judicial or administrative action in which the IAIS or the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer that was shared with the IAIS or the NAIC and its affiliates and subsidiaries under this article.

(e) The sharing of information by the department under this article shall not constitute a delegation of regulatory authority or rulemaking.

(f) The department is solely responsible for the administration, execution and enforcement of the provisions of this article.

(g) The sharing of information by the department as authorized by subsection (c) shall not constitute a waiver of any applicable privilege or claim of confidentiality in the documents, materials or information.

(h) Documents, materials or other information in the possession or control of the IAIS or the NAIC as provided under this article shall:

(1) Be confidential and privileged.
(2) Not be subject to the "Right-to-Know Law."
(3) Not be subject to subpoena.
(4) Not be subject to discovery or admissible in evidence in any private civil action.

(1407 amended July 5, 2012, P.L.1111, No.136)

Section 1408. Regulations.--The department may, in the manner provided by law, promulgate the regulations, and may issue such orders as are necessary to carry out this article.

(1408 amended July 5, 2012, P.L.1111, No.136)

Section 1409. Injunctions and Certain Prohibitions.--(a) Whenever it appears to the department that any insurer or any director, officer, employe or agent thereof has committed or is about to commit a violation of this article or of any regulation or order issued by the department hereunder, the department may apply to the Commonwealth Court for an order enjoining such insurer or such director, officer, employe or agent thereof from violating or continuing to violate this article or any such regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require. ((a) amended July 5, 2012, P.L.1111, No.136)

(b) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this article or of any regulation or order issued by the department hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding, but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this Commonwealth have so ordered. If an insurer or the department has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this article or of any regulation or order issued by the department hereunder, the insurer or the department may apply to the Commonwealth Court to enjoin any offer, request, invitation, agreement or acquisition made in contravention of section 1402, or any regulation or order issued by the department thereunder to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require. ((b) amended July 5, 2012, P.L.1111, No.136)

(c) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this article or any regulation or order issued by the department hereunder, the Commonwealth Court may, on such notice as the court deems appropriate, upon the application of the insurer or the department seize or sequester any voting securities of the insurer owned directly or indirectly by such person and issue such order with respect thereto as may be appropriate to effectuate the provisions of this article. ((c) amended July 5, 2012, P.L.1111, No.136)

(d) Notwithstanding any other provisions of law, for the purposes of this article, the situs of the ownership of the securities of domestic insurers shall be deemed to be in this Commonwealth.

(1409 added Dec. 18, 1992, P.L.1519, No.178)
Section 1410. Sanctions.--(a) A person failing to file any registration statement or any summary of the registration statement or enterprise risk report as required by this article or by regulation shall be required to pay a penalty not to exceed two hundred ($200) dollars for each day's delay. The maximum penalty under this section is twenty-five thousand ($25,000) dollars. ((a) amended July 5, 2012, P.L.1111, No.136)

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in or assents to or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to section 1404(a) or 1405(a)(2) and (b) or which violate this article shall pay, in their individual capacity, a civil forfeiture of not more than twenty-five thousand ($25,000) dollars per violation, after notice and hearing before the department. In determining the amount of the civil forfeiture, the department shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations and such other matters as justice may require.

(c) Whenever it appears to the department that any insurer subject to this article or any director, officer, employe or agent thereof has engaged in any transaction or entered into a contract which is subject to section 1405 and which would not have been approved had such approval been requested, the department may order the insurer to cease and desist immediately any further activity under the transaction or contract. After notice and hearing, the department may also order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

(d) Whenever it appears to the department that any insurer or any director, officer, employe or agent thereof has committed a wilful violation of this article, the department may cause criminal proceedings to be instituted in the common pleas court for the county in which the principal office of the insurer is located or, if such insurer has no such office in this State, then in any other court having jurisdiction against such insurer or the responsible director, officer, employe or agent thereof. Any insurer which wilfully violates this article may be fined not more than one hundred thousand ($100,000) dollars. Any individual who wilfully violates this article may be fined in his individual capacity not more than fifty thousand ($50,000) dollars or be imprisoned for not more than one (1) to three (3) years, or both.

(e) Any officer, director or employe of an insurance holding company system who wilfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the department in the performance of its duties under this article shall, upon conviction, be sentenced to pay a fine of one hundred thousand ($100,000) dollars or to imprisonment for not more than three (3) years, or both. Any fines imposed shall be paid by the officer, director or employe in his individual capacity.

(f) Whenever it appears to the department that a person has committed a violation of this article that prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with section 511 of the

Section 1411. Receivership.--Whenever it appears to the department that any person has committed a violation of this article which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, the department may proceed, in the manner provided by law, to take possession of the property of such domestic insurer and to conduct the business thereof.

Section 1412. Recovery.--(a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the statutory liquidator appointed under such order shall have a right to recover on behalf of the insurer:

(i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than the distributions of shares of the same class of stock, paid by the insurer on its capital stock; or

(ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiaries to a director, officer or employe, where the distribution or payment pursuant to this subsection is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c) and (d).

(b) No such distribution shall be recoverable if the parent or affiliate shows that when paid such distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments under subsection (a) such person received. Any person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to that subsection, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

(1410 added Dec. 18, 1992, P.L.1519, No.178)
Section 1413. Revocation, Suspension or Nonrenewal of Insurer's License.--Whenever it appears to the department that any person has committed a violation of this article which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the department may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or authority to do business in this Commonwealth for such period as it finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.
(1413 added Dec. 18, 1992, P.L.1519, No.178)

ARTICLE XV.
RISK RETENTION.
(Art. added Dec. 18, 1992, P.L.1519, No.178)

Section 1501. Statement of Purpose.--The purpose of this article is to regulate the formation and operation of risk retention groups and purchasing groups in this Commonwealth formed pursuant to the Risk Retention Amendments of 1986 (Public Law 99-563, 100 Stat. 3170) to the extent permitted by such law.
(1501 added Dec. 18, 1992, P.L.1519, No.178)

Section 1502. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Admitted insurer." An insurer with a valid certificate of authority to do insurance business in this Commonwealth.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Completed operations liability." Liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:
(1) any person who performs that work; or
(2) any person who hires an independent contractor to perform that work;
but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

"Department." The Insurance Department of the Commonwealth.

"Doing business." Those acts which constitute the doing of insurance business in this Commonwealth as set forth in section 208(b) of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," except that risk retention groups and purchasing groups are not doing business when responding to a request for coverage received directly from a Pennsylvania resident and not as a result of solicitation.

"Domicile." For purposes of determining the state in which a purchasing group is domiciled, the term means the following:
(1) For a corporation, the state in which the purchasing group is incorporated.
(2) For an unincorporated entity, the state of its principal place of business.

"Eligible surplus lines insurer." A nonadmitted insurer doing business in this Commonwealth in conformance with Article XVI.

"Hazardous financial condition." A condition in which, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:
(1) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or
(2) to pay other obligations in the normal course of business.

"Insurance." Primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this Commonwealth.

"Liability."
(1) The term means legal liability for damages (including costs of defense, legal costs and fees and other claims expenses) because of injuries to other persons, damage to their property or other damage or loss to such other persons resulting from or arising out of:
   (i) any business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations; or
   (ii) any activity of any state or local government, or any agency or political subdivision thereof.
(2) The term does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Employers' Liability Act (34 Stat. 232, 45 U.S.C. § 51 et seq.).

"Nonadmitted insurer." An insurer that does not have a certificate of authority to do insurance business in this Commonwealth. The term includes insurance exchanges authorized under laws of various states.

"Personal risk liability." A liability for damages because of injury to any person, damage to property or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in the definition of "liability."

"Plan of operation or a feasibility study." An analysis which presents the expected activities and results of a risk retention group, including, at a minimum, all of the following:
(1) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations.
(2) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each kind of liability insurance the group intends to offer.
(3) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available.
(4) Pro forma financial statements and projections.
(5) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition.
(6) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements.
(7) The states in which the risk retention group intends to operate or is currently operating.
(8) Such other matters as may be prescribed by the department for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered.
"Product liability." Liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product. The term does not include the liability of any person for these damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

"Purchasing group." Any group which:
(1) has as one of its purposes the purchase of liability insurance on a group basis;
(2) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (3);
(3) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and
(4) is domiciled in any state.

"Risk retention group." Any corporation or other limited liability association:
(1) whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;
(2) which is organized for the primary purpose of conducting the activity described under paragraph (1);
(3) which:
   (i) is chartered and licensed as an insurance company to write liability insurance and authorized to engage in the business of insurance under the laws of any state; or
   (ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance department of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981 (Public Law 97-45, 95 Stat. 949), before the date of the enactment of the Risk Retention Amendments of 1986 (Public Law 99-563, 100 Stat. 3170);
(4) which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;
(5) which:
   (i) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or
   (ii) has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and which organization has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the risk retention group;
(6) whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;
(7) whose activities do not include the provision of insurance other than:
  (i) liability insurance for assuming and spreading all or any portion of the liability of its group members; and
  (ii) reinsurance with respect to the liability of any other risk retention group (or any members of such other risk retention group) which is engaged in businesses or activities so that the group or member meets the requirement described in paragraph (6) for membership in the risk retention group which provides such reinsurance; and
(8) the name of which includes the phrase "Risk Retention Group."

"State." Any state of the United States or the District of Columbia.

(1502 added Dec. 18, 1992, P.L.1519, No.178)

Section 1503. Risk Retention Groups Chartered in this Commonwealth.--(a) A domestic risk retention group shall, pursuant to this act and the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," be chartered and licensed as a domestic fire or casualty insurance company to write only liability insurance pursuant to this article and, except as provided elsewhere in this article, shall comply with all the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this Commonwealth and with section 1504 to the extent that such requirements are not a limitation of laws, rules, regulations or requirements of this Commonwealth.

(b) Before it may offer insurance in any state, each domestic risk retention group shall also submit for approval to the department a plan of operation or a feasibility study. In the event of any subsequent material change in any item of the plan of operation or feasibility study, the risk retention group shall submit an appropriate revision within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance in this Commonwealth or in any other state until a revision of such plan or study is approved by the department.

(c) The provisions of subsection (b), relating to the submission of a plan of operation or feasibility study, shall not apply with respect to any kind or classification of liability insurance which:
  (1) was defined in the Product Liability Risk Retention Act of 1981 (Public Law 97-45, 95 Stat. 949), before October 27, 1986; and
  (2) was offered before such date by any risk retention group which had been chartered and operating for not less than three (3) years before such date.

(d) At the time of filing its application for charter, the risk retention group shall provide to the department in summary form the following information:
  (1) The identity of the initial members of the group.
  (2) The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group.
  (3) The amount and nature of initial capitalization.
  (4) The coverages to be afforded.
  (5) The states in which the group intends to operate.

(1503 added Dec. 18, 1992, P.L.1519, No.178)

Section 1504. Risk Retention Groups not Chartered in this Commonwealth.--(a) A risk retention group chartered and licensed in a state other than this Commonwealth and seeking
to do business as a risk retention group in this Commonwealth shall comply with the laws of this Commonwealth, as provided in this section.

(b) Before doing business in this Commonwealth, a risk retention group shall submit to the department all of the following:

(1) A statement identifying the state or states in which the risk retention group is chartered and licensed as an insurance company to write liability insurance, the charter date, its principal place of business and such other information, including information on its membership, as the department may require to verify that the risk retention group is qualified under the definition of "risk retention group" in section 1502.

(2) A copy of its plan of operations or a feasibility study and copies of all revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed, provided that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any kind or classification of liability insurance which:

(i) was defined in the Product Liability Risk Retention Act of 1981 (Public Law 97-45, 95 Stat. 949 et seq.) before October 27, 1986; and

(ii) was offered before such date by any risk retention group which had been chartered and was operating for not less than three (3) years before such date.

(3) A copy of the most recent annual statement as described in subsection (d)(1).

(4) (i) A statement of registration for which a filing fee shall be imposed, which statement appoints the department as its agent for the purpose of receiving service of legal documents or process.

(ii) The appointment of the department shall be accompanied by written designation of the name and address of the officer, agent or other person to whom such process shall be forwarded by the department or its deputy on behalf of such risk retention group. In the event such designation is changed, a new certificate of designation shall be filed with the department within ten (10) days of such change.

(iii) Service of process upon a risk retention group pursuant to this paragraph shall be made by serving the department, or any deputy thereof or any salaried employe of the department whom the department designates for such purpose, with two copies thereof and the payment of a fee to be published by notice in the Pennsylvania Bulletin. The department shall forward a copy of such process by registered or certified mail to the risk retention group at the address given in its written certificate of designation and shall keep a record of all process so served upon it. Service of process so made shall be deemed made within the territorial jurisdiction of any court in this Commonwealth.

(c) The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by section 1503(b) at the same time that such revision is submitted to the department of its chartering state.

(d) Any risk retention group doing business in this Commonwealth shall submit annually to the department on or before March 1 all of the following:

(1) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which shall be certified by an independent public
accountant and shall contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist.

(2) A copy of the most recent examination of the risk retention group as certified by the department or public official conducting the examination.

(3) Upon request by the department, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group.

(4) Such information as may be required to verify its continuing qualification as a risk retention group, as defined in section 1502.

(e) If a risk retention group is found to be in a hazardous financial condition by any court of competent jurisdiction, the risk retention group shall submit a copy of the court order to the department within ten (10) days of the date of the order.

(f) A risk retention group shall be liable for a fine of two hundred ($200) dollars per day of delinquency for either of the following:

(1) Failure to file the annual statement as provided by law on the first day of March, except that, for good cause shown, the department may grant, after written request, a reasonable extension of time within which such statement may be filed.

(2) Failure to submit to the department a copy of the order of a court of competent jurisdiction finding the risk retention group to be in a hazardous financial condition or financially impaired within ten (10) days of the date of such order.

(g) (1) Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this Commonwealth and shall report to the department the gross direct premiums, less returns thereon, written for risks resident or located within this Commonwealth. Such risk retention group shall be subject to taxation and any applicable fines and penalties related thereto on the same basis as a foreign admitted insurer, pursuant to section 902 of the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971."

(2) To the extent that licensed agents, brokers or surplus lines agents with Pennsylvania licenses are utilized pursuant to section 1514, they shall report to the department the premiums for direct business for risks resident or located within this Commonwealth which such licensees have placed with or on behalf of a risk retention group not chartered and licensed in this Commonwealth.

(h) Any risk retention group and its agents and representatives shall comply with the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act," insofar as its provisions apply to unfair claims practices and deceptive, false or fraudulent practices. However, if the department seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(i) Any risk retention group shall submit to an examination by the Insurance Department of the Commonwealth to determine its financial condition if the department of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the Insurance Commissioner of the Commonwealth. Any such examination shall be coordinated with other jurisdictions to the extent feasible in order to avoid unjustified repetition and shall be conducted in an expeditious
manner and in accordance with The National Association of Insurance Commissioners' Examination Handbook.

(j) The terms of any insurance policy issued by such risk retention group shall not provide or be construed to provide insurance policy coverage prohibited generally by state statute or declared unlawful by the highest court of the state whose law applies to such policy.

(k) A risk retention group doing business in this Commonwealth shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance department if there has been a finding of hazardous financial condition or financial impairment after an examination under subsection (i).

(l) Any risk retention groups doing business in this Commonwealth prior to the enactment of this article shall, within thirty (30) days after the effective date of this article, comply with the provisions of this section.

(m) A risk retention group which violates any provision of this article shall be subject to fines and penalties applicable to admitted insurers generally, including revocation of its right to do business in this Commonwealth.

(1504 added Dec. 18, 1992, P.L.1519, No.178)

Section 1505. Notice and Prohibited Acts.--(a) Every application form for insurance from a risk retention group and every policy issued by a risk retention group shall contain, in ten-point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(b) The following acts by a risk retention group are hereby prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group.

(2) The solicitation or sale of insurance by or operation of a risk retention group that has been found by a court of competent jurisdiction to be in a hazardous financial condition or financially impaired.

(c) No risk retention groups shall be allowed to do business in this Commonwealth if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(1505 added Dec. 18, 1992, P.L.1519, No.178)

Section 1506. Guaranty Funds and Compulsory Associations.--(a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this Commonwealth, nor shall any risk retention group or its insureds or claimants against its insureds receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

(b) When a purchasing group obtains insurance covering its members' risks from an insurer not admitted in this Commonwealth or from a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this Commonwealth.
(c) When a purchasing group obtains insurance covering its members' risks from an admitted insurer, only covered claims as defined in the act of November 25, 1970 (P.L.716, No.232), known as "The Pennsylvania Insurance Guaranty Association Act," shall be covered by the State guaranty fund.

(d) The department may require risk retention groups not chartered in this Commonwealth to participate and may exempt domestic risk retention groups from participation in any mechanism established or authorized under the laws of this Commonwealth for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism, and such risk retention groups shall submit sufficient information to the department to enable the department to apportion on a nondiscriminatory basis the risk retention group's proportionate share of such losses and expenses.

(1506 added Dec. 18, 1992, P.L.1519, No.178)

Section 1507. Countersignatures Not Required.--(1507 repealed Dec. 21, 1998, P.L.1108, No.150)

Section 1508. Exemption.--(a) A purchasing group and its insurer or insurers shall be subject to all applicable laws of this Commonwealth, except that the purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would do any of the following:

(1) Prohibit the establishment of a purchasing group.
(2) Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages, based on their loss and expense experience, not afforded to other persons with respect to rates, policy forms, coverages or other matters.
(3) Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph (2).
(4) Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time.
(5) Require that a purchasing group must have a minimum number of members, common ownership or affiliation or a certain legal form.
(6) Require that a certain percentage of a purchasing group must obtain insurance on a group basis.
(7) Otherwise discriminate against a purchasing group or any of its members.

(b) An insurer shall be exempt from any laws of this Commonwealth which prohibits providing or offering to provide, to a purchasing group or its members, advantages, based on their loss and expense experience, not afforded to other persons with respect to rates, policy forms, coverages or other matters.

(1508 added Dec. 18, 1992, P.L.1519, No.178)

Section 1509. Notice and Registration Requirements.--(a) A purchasing group which intends to do business in this Commonwealth shall, prior to doing such business, furnish notice to the department which notice shall do all of the following:

(1) Identify the state in which the group is domiciled.
(2) Identify the principal place of business of the group.
(3) Identify all other states in which the group intends to do business or is doing business.
(4) Specify the kinds and classifications of liability insurance which the purchasing group intends to purchase.
(5) Specify the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this Commonwealth.

(6) Identify the names and chartering jurisdictions of the insurance company or companies from which the group intends to purchase its insurance.

(7) Confirm that the insurer from which the purchasing group intends to purchase insurance has filed with the department, pursuant to section 354 and all other provisions of insurance laws, rules and regulations governing policy form and rate standards, the rates and forms it intends to use to provide coverage for the risks resident in this Commonwealth.

(8) Provide such other information as may be required by the department to verify that the purchasing group is qualified under the definition of "purchasing group" in section 1502.

(b) A purchasing group shall notify the department within ten (10) days as to any subsequent changes in any of the items set forth in subsection (a).

(c) Each purchasing group which is required to give notice pursuant to subsection (a) shall also furnish such information as may be required by the department to do any of the following:

(1) Verify that the entity qualifies as a purchasing group.

(2) Determine the location of the purchasing group.

(3) Determine appropriate tax treatment.

(d) (1) The purchasing group shall submit a statement of registration, for which a filing fee shall be imposed, which designates the department as its agent solely for the purpose of receiving service of legal documents or process.

(2) The designation of the department shall be accompanied by written designation of the name and address of the officer, agent or other person to whom such process shall be forwarded by the department or its deputy on behalf of such purchasing group. In the event such designation is changed, a new certificate of designation shall be filed with the department within ten (10) days of such change.

(3) Service of process upon a purchasing group pursuant to this subsection shall be made by serving the department, any deputy thereof or any salaried employee of the department whom the department designates for such purpose with two copies thereof and the payment of a fee to be published by notice in the Pennsylvania Bulletin. The department shall forward a copy of such process by registered or certified mail to the purchasing group at the address given in its written certificate of designation and shall keep a record of all process so served upon it. Service of process so made shall be deemed made within the territorial jurisdiction of any court in this Commonwealth.

(4) Such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the Products Liability Risk Retention Act of 1981 (Public Law 97-45, 95 Stat. 949); and

(i) which in any state of the United States:

(A) was domiciled before April 1, 1986; and

(B) is domiciled on and after October 27, 1986; and

(ii) which:

(A) before October 27, 1986, purchased insurance from an insurance company licensed in any state;

(B) since October 27, 1986, purchased its insurance from an insurance company licensed in any state;

(C) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986; and
(D) does not purchase insurance that was not authorized for purposes of an exemption under that article, as in effect before October 27, 1986.
(e) Any purchasing group which was doing business in this Commonwealth prior to the enactment of this act shall, within thirty (30) days after the effective date of this article, furnish notice to the department pursuant to the provisions of subsection (a) and furnish such information as may be required pursuant to subsections (b), (c) and (d).
(1509 added Dec. 18, 1992, P.L.1519, No.178)
Section 1510. Restrictions on Insurance Purchased by Purchasing Groups.--(a) A purchasing group may purchase liability insurance for its members who are residents of this Commonwealth only from:
(1) a risk retention group chartered and licensed in this Commonwealth;
(2) an admitted insurer;
(3) a risk retention group not chartered and licensed in this Commonwealth which has complied with section 1503; or
(4) an eligible surplus lines insurer if the liability insurance is obtained through surplus lines agents acting pursuant to Article XVI.
(b) The terms of any liability insurance policy obtained by a purchasing group shall not provide or be construed to provide insurance coverage prohibited generally by state statute or declared unlawful by the highest court of the state whose law applies to such policy. If the laws of this Commonwealth apply to an insurance policy obtained by a purchasing group, the terms of that policy shall not provide or be construed to provide insurance coverage prohibited generally by state statute or declared unlawful by the highest court of this Commonwealth which has construed such coverage.
(c) A purchasing group which obtains liability insurance from a nonadmitted insurer that is an eligible surplus lines insurer in this Commonwealth or from a risk retention group shall inform each of the members of such purchasing group which has a risk resident or located in this Commonwealth that such risk is not protected by an insurance insolvency guaranty fund in this Commonwealth and that such risk retention group or such nonadmitted insurer may not be subject to all insurance laws and regulations of this Commonwealth.
(d) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.
(e) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.
(1510 added Dec. 18, 1992, P.L.1519, No.178)
Section 1511. Insurance Company Interest in Purchasing Groups Doing Business in this Commonwealth Prohibited.--No insurer or director, officer or employe of an insurer may have any interest in a purchasing group doing business in this Commonwealth. Prohibited interest includes, but is not limited to, soliciting members for the purchasing group and belonging to the purchasing group as a member, provided that nothing in this section will prohibit a purchasing group composed entirely of insurers or directors, officers or employees of insurers if coverage is obtained from a company not related to the group members.
(1511 added Dec. 18, 1992, P.L.1519, No.178)
Section 1512. Taxation of Premiums Paid by Purchasing Groups.--(a) (1) Premiums paid for coverage obtained from admitted insurers and risk retention groups doing business in this Commonwealth shall be taxed on the same basis as premiums paid to admitted insurers under section 902 of the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971."
(2) Premiums paid for coverage obtained from a nonadmitted insurer in compliance with this article shall be taxed at the rate applicable to premiums paid to surplus lines insurers pursuant to section 1621(a).
(b) (1) To the extent that the purchasing group or its members pay premiums for coverage of risks resident or located within this Commonwealth to admitted insurers or risk retention groups doing business in this Commonwealth, the insurer or risk retention group receiving those premiums is responsible for remitting the tax to the Department of Revenue.
(2) To the extent that the purchasing group or its members pay premiums for coverage of risks resident or located within this Commonwealth to a nonadmitted insurer, the surplus lines agent who places the business shall collect and remit the taxes for premiums.
(3) To the extent a surplus lines agent does not effect coverage, the purchasing group shall collect and remit the tax for coverage of risks resident or located in this Commonwealth. To the extent the purchasing group does not remit the tax, the purchasing group shall inform each member of the responsibility for individual remittance of the tax.
(1512 added Dec. 18, 1992, P.L.1519, No.178)
Section 1513. Administrative and Procedural Authority Regarding Risk Retention Groups and Purchasing Groups.--The department is authorized to make use of any of the powers established under the insurance laws of this Commonwealth to enforce the laws of this Commonwealth not specifically preempted by the Risk Retention Amendments of 1986 (Public Law 99-563, 100 Stat. 3170), including the department's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the department may rely on the procedural laws of this Commonwealth. The injunctive authority of the department in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.
(1513 added Dec. 18, 1992, P.L.1519, No.178)
Section 1514. Duty of Agent or Broker to Obtain License.--(a) (1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this Commonwealth for a risk retention group unless such person, firm, association or corporation is licensed either as an insurance agent in accordance with section 603 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," or as an insurance broker in accordance with section 622 of "The Insurance Department Act of one thousand nine hundred and twenty-one."
(2) No person, firm, association or corporation shall act or aid in any manner in negotiating or procuring liability insurance in this Commonwealth for a purchasing group or for any of its members from an admitted insurer or a risk retention group unless such person, firm, association or corporation is licensed either as an insurance agent in accordance with section 603 of "The Insurance Department Act of one thousand nine
hundred and twenty-one" or as an insurance broker in accordance with section 622 of "The Insurance Department Act of one thousand nine hundred and twenty-one."

(b) (1) No person, firm, association or corporation shall act or aid in any manner in negotiating or procuring liability insurance from a nonadmitted insurer on behalf of a purchasing group unless such person, firm, association or corporation is licensed as a surplus lines agent in accordance with section 1615.

(2) Notwithstanding the provisions of section 1615, a nonresident of this Commonwealth who acts in this Commonwealth solely on behalf of a purchasing group or a risk retention group in obtaining liability insurance with a nonadmitted insurer is exempt from the requirements of maintaining an office in this Commonwealth in order to obtain a surplus lines agent's license for the limited purpose of effecting coverage for such purchasing group or risk retention group.

((b) amended Feb. 17, 1994, P.L.92, No.9)

(c) Every person, firm, association or corporation licensed pursuant to the provisions of this section shall inform each prospective insured of the provisions of the notice required by section 1505(a) in the case of a risk retention group and by section 1510(c) in the case of a purchasing group.

(d) This section shall not apply to officers or salaried employees of any risk retention group or purchasing group who do not solicit, negotiate or place risks.

(1514 added Dec. 18, 1992, P.L.1519, No.178)

Section 1515. Financial Responsibility.--(a) Whenever, pursuant to the laws of this Commonwealth or any local law, a demonstration of financial responsibility is required as a condition for obtaining a license or permit to undertake specified activities, if any such requirement may be satisfied only by obtaining insurance coverage from an admitted insurer or nonadmitted insurer that qualifies as an eligible surplus lines insurer, such requirement may not be satisfied by purchasing insurance from a risk retention group not chartered and licensed in this Commonwealth or through a purchasing group which has purchased coverage from a risk retention group not chartered and licensed in this Commonwealth.

(b) Any risk retention group and any insurer who transacts the business of insurance in this Commonwealth with a purchasing group or its members shall not be exempt from the policy form or coverage requirements of 75 Pa.C.S. Ch. 17 (relating to financial responsibility).

(1515 added Dec. 18, 1992, P.L.1519, No.178)

Section 1516. Order of United States District Court.--An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state or in all states or in any territory or possession of the United States, upon a finding that such a group is in a hazardous financial or financially impaired condition, shall be enforceable in the courts of this Commonwealth.

(1516 added Dec. 18, 1992, P.L.1519, No.178)

ARTICLE XVI.
SURPLUS LINES.
(Art. added Dec. 18, 1992, P.L.1519, No.178)

Section 1601. Purpose and scope.--(a) The purpose of this article is to protect the public interest by:
(1) Protecting persons seeking insurance in this Commonwealth.
(2) Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this Commonwealth pursuant to this article.
(3) Establishing a system of regulation which will permit orderly access to surplus lines insurance in this Commonwealth and encouraging insurers to make new and innovative types of insurance available to consumers in this Commonwealth.
(4) Protecting revenues of this Commonwealth.
(b) (1) The provisions of this article, insofar as they relate to the placement of surplus lines insurance and independently procured insurance, shall apply when this Commonwealth is the home state of the insured.
(2) The provisions of this article, insofar as they relate to the imposition of surplus lines and independently procured premium tax and penalties for policies placed after June 30, 2011, shall apply when this Commonwealth is the home state of the insured.
(3) The provisions of this article, insofar as they relate to the collection, reporting and remittance of surplus lines insurance and independently procured insurance premium tax for policies placed after June 30, 2011, shall apply when this Commonwealth is the home state of the insured.
(1601 amended June 30, 2011, P.L.194, No.28)
Section 1602. Definitions.—As used in this article the following words and phrases shall have the meanings given to them in this section:
"Admitted insurer." An insurer licensed to do an insurance business in this Commonwealth.
"Affiliate." With respect to an insured, any entity that controls, is controlled by or is under common control with the insured.
"Affiliated group." Any group of entities that are all affiliated.
"Business entity." A corporation, a partnership, a limited liability company, a limited liability partnership, a business trust or any other entity doing business other than as a natural person.
"Capital." The term, as used in the financial requirements of section 1605, means funds paid for stock or other evidence of ownership.
"Commissioner." The Insurance Commissioner of the Commonwealth.
"Control." An entity has control over another entity if:
(1) the entity directly or indirectly or acting through one or more other persons owns, controls or has the power to vote twenty-five per centum (25%) or more of any class of voting securities of the other entity; or
(2) the entity controls in any manner the election of a majority of the directors or trustees of the other entity.
"Department." The Insurance Department of the Commonwealth.
"Eligible surplus lines insurer." A nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under section 1604.
"Export." To place surplus lines insurance with either a nonadmitted insurer or an eligible surplus lines insurer in accordance with this article.
"Home state." (1) Except as provided under paragraph (2), with respect to an insured:
(i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or
(ii) if one hundred per cent (100%) of the insured risk is located out of the state referred to under subparagraph (i), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(2) If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term means the home state, as determined under paragraph (1), of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract.

(3) This definition shall not apply to section 1615(g).

"Independently procured insurance." Any insurance directly procured by an insured from a nonadmitted insurer.

"Insurance producer." A person that is licensed to sell, solicit or negotiate contracts of insurance with admitted insurers.

"Kind of insurance." One of the types of insurance required to be reported in the annual statement which must be filed with the department by admitted insurers.

"Nonadmitted insurer." An insurer not authorized and not licensed to do an insurance business in this Commonwealth. The term includes insurance exchanges as authorized under the laws of various states. The term does not include a risk retention group.

"Person." A natural person or business entity.

"Producing broker." (Def. deleted by amendment Mar. 22, 2010, P.L.147, No.14)


"State." Any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands and American Samoa.

"Surplus." The term, as used in the financial requirements of section 1605, means funds over and above liabilities and capital of the company for the protection of its policyholders.

"Surplus lines insurance." Any insurance permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, wet marine and transportation insurance, independently procured insurance, life insurance and annuities and coverage obtained from risk retention groups under the Risk Retention Amendments of 1986 (Public Law 99-563, 100 Stat. 3170).

"Surplus lines licensee." A person licensed as a surplus lines producer under section 1615 to place surplus lines insurance with nonadmitted insurers eligible to accept such insurance.

"Type of insurance." Coverage afforded under the particular policy that is being placed.

"Wet marine and transportation insurance." Any of the following:
(1) Insurance upon vessels, crafts or hulls and of interests therein or with relation thereto.
(2) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance.
(3) Insurance of freights and disbursements pertaining to a subject of insurance coming within this definition.

(4) Insurance of personal property and interest therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment or reshipment. Insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if:
   (i) the property has been transported solely by land;
   (ii) the property has reached its final destination as specified in the bill of lading or other shipping document; or
   (iii) the insured no longer has an insurable interest in the property.

(5) Any insurance associated with transportation of property listed under this definition.

"Writing producer." The insurance producer which brings about or negotiates contracts of insurance directly on behalf of the consumer seeking insurance.

(1602 amended June 30, 2011, P.L.194, No.28)

Section 1603. Acting for or Aiding Nonadmitted Insurers.—(a) No person in this Commonwealth shall directly or indirectly act as a producer for, or otherwise represent or aid on behalf of another, any nonadmitted insurer in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist such insurer in the transaction of insurance.

(b) If the nonadmitted insurer is not an eligible surplus lines insurer and fails to pay a claim or loss within the provisions of the insurance contract, a person who assisted or in any manner aided, directly or indirectly, in the procurement of the insurance contract shall be liable to the insured for the full amount payable under the provisions of the insurance contract.

(c) This section does not apply to any of the following:
   (1) Surplus lines insurance if it is effected and written pursuant to this article.
   (2) Insurance effected with a nonadmitted insurer pursuant to sections 1606 and 1610.
   (3) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this Commonwealth.
   (4) Reinsurance.
   (5) Wet marine and transportation insurance.
   (6) Transactions subsequent to issuance of a policy in which this Commonwealth becomes the home state. ((6) amended June 30, 2011, P.L.194, No.28)
   (7) Transactions involving risk retention groups chartered and licensed outside of this Commonwealth.


Section 1604. Placement of Surplus Lines Insurance.—Insurance may be procured through a surplus lines licensee from nonadmitted insurers if the following requirements are met:

(1) Each insurer is an eligible surplus lines insurer.
(2) The placement satisfies the criteria set forth in at least one of the following subparagraphs:

(i) The full amount or kind of insurance cannot be obtained from admitted insurers. Such full amount or kind of insurance or any portion thereof may be procured from eligible surplus lines insurers, provided that a diligent search is made among the admitted insurers who are writing, in this Commonwealth, coverage comparable to the coverage being sought.

(ii) The full amount or kind of insurance cannot be obtained from any admitted insurers because coverage comparable to the coverage being sought generally is not available in the authorized market.

(iii) The kind of insurance sought to be obtained from admitted insurers requires a unique form of coverage not available in the admitted market.

(3) With respect to personal lines policies or contract forms, the policy or contract form used by the insurer does not differ materially from policies or contracts customarily used by admitted insurers for the kind of insurance involved. Personal lines coverage may be placed in an eligible surplus lines insurer using a unique form or policy designed for the kind of insurance only if a copy of such form is first filed with the department by the surplus lines licensee desiring to use it. The form shall be deemed approved by the commissioner unless, within ten (10) days after receipt of the same, the commissioner shall find that the use of such form will be contrary to law or public policy.

(4) All other requirements of this article are met.

(1604 amended July 10, 2002, P.L.749, No.110)

Section 1605. Requirements for Eligible Surplus Lines Insurers.--(a) No surplus lines licensee shall place any coverage with a nonadmitted insurer unless, at the time of placement, such nonadmitted insurer qualifies under one of the following:

(1) (i) is authorized to write the type of insurance in its domiciliary jurisdiction; and
(ii) has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which is greater than or equal to fifteen million ($15,000,000) dollars. The requirement of this subparagraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand ($4,500,000) dollars.

(2) If domiciled outside the United States, is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

((a) amended June 30, 2011, P.L.194, No.28)

(b) In addition to meeting the requirements in subsection (a), a nonadmitted insurer shall be an eligible surplus lines insurer if it appears on the most recent list of eligible surplus lines insurers published by the department from time to time but at least annually. Nothing in this section shall require the department to place or maintain the name of any nonadmitted insurer on the list of eligible surplus lines insurers.
Section 1606. Other Nonadmitted Insurers.--Only that portion, not to exceed twenty-five per centum (25%), of any risk eligible for export for which the full amount of coverage is not procurable from either admitted insurers or eligible surplus lines insurers may be placed with any other nonadmitted insurer which does not appear on the list of eligible surplus lines insurers published by the department pursuant to section 1605(b) but nonetheless meets the requirements set forth in section 1605(a) and any regulations of the department. The surplus lines licensee providing coverage through a nonadmitted insurer which is not an eligible surplus lines insurer shall make a filing specifying the amount and percentage of each risk along with a full explanation of why the risk could not be placed with admitted or eligible surplus lines insurers and naming the nonadmitted insurer with which placement was made. At the time of presenting a quotation to the insured, the surplus lines licensee shall present to the insured or to the writing producer written notice that a portion of the insurance will be placed with such nonadmitted insurer.

Section 1607. Withdrawal of Eligibility from a Surplus Lines Insurer.--If at any time the department has reason to believe that an eligible surplus lines insurer:

(1) is in unsound financial condition;
(2) is no longer eligible under section 1605;
(3) has wilfully violated the laws of this Commonwealth;

or

(4) does not make reasonably prompt payment of just losses and claims in this Commonwealth or elsewhere;

the department may declare it ineligible. The department shall promptly mail notice of all such declarations to each surplus lines licensee and, in the event the department's action is based upon paragraph (4), the notice shall be issued at least thirty (30) days prior to the effective date of the withdrawal of eligibility.

Section 1608. Surplus Lines Licensee's Duty to Notify Insured.--At the time of presenting a quotation to the insured, the surplus lines licensee shall present to the insured or to the writing producer written notice that the insurance or a portion thereof involves placement with nonadmitted insurers. The surplus lines licensee shall, either directly or through the writing producer, give notice to the insured that:

(1) the insurer with which the licensee places the insurance is not licensed by the department and is subject to its limited regulation; and
(2) in the event of the insolvency of an eligible surplus lines insurer, losses will not be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association.

Section 1609. Declarations.--(a) In the case of each placement of insurance in accordance with this article:

(1) Within thirty (30) days after the surplus lines licensee has placed insurance with an eligible surplus lines insurer, the writing producer must execute and forward to the surplus lines licensee a written statement, in a form prescribed by the department, declaring that:

(i) A diligent effort to procure the desired coverage from admitted insurers was made.

(ii) The insured was expressly advised in writing prior to placement of the insurance that:
(A) the insurer with whom the insurance is to be placed is not admitted to transact business in this Commonwealth and is subject to limited regulation by the department; and
(B) in the event of the insolvency of the insurer, losses will not be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association.

This written declaration shall be open to public inspection.

(2) Within forty-five (45) days after insurance has been placed in an eligible surplus lines insurer, the surplus lines licensee shall file with the department a written declaration of his lack of knowledge of how the coverage could have been procured from admitted insurers. The surplus lines licensee shall simultaneously file the written declaration of the writing producer, as set forth in paragraph (1).

(3) In a particular transaction where the writing producer and surplus lines licensee are one in the same entity, the writing producer or surplus lines licensee shall execute both declarations.

(b) Subsection (a) shall not apply to any insurance which has been placed continuously with an eligible surplus lines insurer for a period of at least three (3) consecutive years immediately preceding the current placement. However, within forty-five (45) days after insurance has been placed with an eligible surplus lines insurer, the surplus lines licensee shall file with the department his written declaration on a form prescribed by the department.


Section 1610. Exempt Risks.--(a) ((a) deleted by amendment June 30, 2011, P.L.194, No.28)

(a.1) The diligent search requirements of section 1604(2), the reporting requirements of section 1609(a) and the twenty-five per centum (25%) limitation of section 1606 shall not apply to placements of insurance with nonadmitted insurers for an exempt commercial purchaser if:
(1) the surplus lines licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that the insurance may be available from the admitted market that may provide greater protection with more regulatory oversight; and
(2) the exempt commercial purchaser has subsequently requested in writing the surplus lines licensee to procure or place the insurance from a nonadmitted insurer.

((a.1) added June 30, 2011, P.L.194, No.28)

(b) (1) The diligent search requirement of section 1604(2) and the reporting requirements of section 1609(a) are not applicable to placements of insurance with eligible surplus lines insurers for:
(i) Risks of members of a purchasing group established under the Risk Retention Amendments of 1986 (Public Law 99-563, 100 Stat. 3170) if all of the insured members of the purchasing group are covered under its group policy or if the members are additional named insureds under the group's policy.
(ii) Risks of members of a risk retention group established under the Risk Retention Amendments of 1986.

(2) Within forty-five (45) days after insurance has been placed with an eligible surplus lines insurer for members of a purchasing group or risk retention groups by a surplus lines licensee, the licensee shall file with the department his written declaration, reporting the transaction on a form prescribed by the department.
(c) The following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Exempt commercial purchaser." Any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

1. The person employs or retains a qualified risk manager to negotiate insurance coverage.
2. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand ($100,000) dollars in the immediately preceding twelve (12) months.
3. (i) The person meets at least one of the following criteria:
   (A) The person possesses a net worth in excess of twenty million ($20,000,000) dollars, as adjusted under subparagraph (ii).
   (B) The person generates annual revenues in excess of fifty million ($50,000,000) dollars, as adjusted under subparagraph (ii).
   (C) The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate.
   (D) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million ($30,000,000) dollars, as adjusted under subparagraph (ii).
   (E) The person is a municipality with a population in excess of fifty thousand (50,000) persons.
(ii) Beginning January 1, 2015, and every five (5) years thereafter, the amounts under clauses (A), (B) and (D) shall be adjusted to reflect the percentage change for the five-year (5) period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor and Industry.

"Qualified risk manager." With respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

1. The person is an employee of or third-party consultant retained by the commercial policyholder.
2. The person provides skilled services in loss prevention, loss reduction or risk and insurance coverage analysis and purchase of insurance.
3. The person:
   (i) (A) has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics or any other field determined by the commissioner to demonstrate minimum competence in risk management; and
   (B) (I) has three (3) years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis or purchasing commercial lines of insurance; or
   (II) has:
      (a) a designation as a Chartered Property and Casualty Underwriter issued by the American Institute for Chartered Property and Casualty Underwriter and Insurance Institute of America;
      (b) a designation as an Associate in Risk Management issued by the American Institute for Chartered Property and Casualty Underwriter and Insurance Institute of America;
(c) a designation as Certified Risk Manager issued by the National Alliance for Insurance Education & Research;
(d) a designation as a RIMS Fellow issued by the Global Risk Management Institute; or
(e) any other designation, certification or license determined by the commissioner to demonstrate minimum competency in risk management;
(ii) (A) has at least seven (7) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; and
(B) has any one of the designations specified under clauses (a), (b), (c), (d) and (e);
(iii) has at least ten (10) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; or
(iv) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics or any other field determined by the commissioner to demonstrate minimum competence in risk management.
((c) added June 30, 2011, P.L.194, No.28)
(1610 added Dec. 18, 1992, P.L.1519, No.178)
Section 1611. Surplus Lines Advisory Organizations.--(a) A surplus lines advisory organization of surplus lines licensees may be formed to:
(1) Facilitate and encourage compliance by surplus lines licensees with the laws of this Commonwealth and the rules and regulations of the department relative to surplus lines insurance.
(2) Provide means for the examination, which shall remain confidential, of all surplus lines coverages written by surplus lines licensees to determine whether such coverages comply with such laws and regulations.
(3) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market.
(4) Receive and disseminate to surplus lines licensees information relative to surplus lines insurance.
(b) The functions of the organization shall in no way supplant or delegate current regulatory authority of the department to administer the provisions of this article.
(c) An advisory organization shall file with the department for approval:
(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation.
(2) A copy of its bylaws, rules and regulations governing its activities.
(3) (Deleted by amendment).
(4) The name and address of a resident of this Commonwealth upon whom notices or orders of the department or processes issued at its direction may be served.
(5) An agreement that the department may examine such advisory organization in accordance with the provisions of this section.
(d) The department may, as necessary, make or cause to be made an examination of each such advisory organization. The reasonable cost of any such examination shall be paid by the advisory organization upon presentation to it by the department of a detailed account of each cost. The officers, directors, managers, agents and employes of such advisory organization may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its
method of operation. The department shall furnish two copies of the examination report to the advisory organization examined and shall notify such organization that it may, within twenty (20) days thereof, request a hearing on the report or on any facts or recommendations therein. If the department finds such advisory organization or any member thereof to be in violation of this article, it may issue a cease and desist order requiring the discontinuance of such violation and may impose any other penalties as set forth in this article.

(e) The department may contract with a surplus lines advisory organization to render advice and assistance in carrying out the purposes of this article. The services performed by the advisory organization pursuant to such contract may be funded by a stamping fee assessed on each surplus lines policyholder whose policy is submitted to the advisory organization. The stamping fee shall be established by the board of governors of the advisory organization, from time to time, and shall be subject to approval by the department.

(f) The advisory organization may submit reports and make recommendations to the department regarding the financial condition of any eligible surplus lines insurer. These reports and recommendations shall not be considered to be public information or subject to any Federal or state freedom of information law. There shall be no liability on the part of nor shall any cause of action of any nature be sustained against eligible surplus lines insurers, the advisory organization or its members, agents, employees, officers or directors or the department or authorized representatives of the department for statements and any reports or recommendations made by them in good faith under this section. ((f) amended June 30, 2011, P.L.194, No.28)

(g) By order of the department, a surplus lines licensee may be compelled to attend educational seminars as a condition of continued licensure under this article. (1611 amended Mar. 22, 2010, P.L.147, No.14)

Section 1612. Evidence of Insurance.--(a) Upon placing surplus lines insurance, the surplus lines licensee shall deliver to the insured or the writing producer the contract of insurance. If the contract of insurance is not immediately available, a cover note, binder or other evidence of insurance shall be delivered by the surplus lines licensee to the insured or the writing producer and shall, at a minimum, show the description and location of the subject of insurance, coverages, including any material limitations other than those in standard forms, the premium and rate charged and taxes to be collected from the insured, the name and address of the insured and the eligible surplus lines insurer and other nonadmitted insurer involved under section 1606 and proportion of the risk assumed by each, and the name of the surplus lines licensee.

(b) No surplus lines licensee shall bind or provide evidence of insurance unless he has authority from the eligible surplus lines insurer or other nonadmitted insurer to bind the risk or has received information from the insurer in the regular course of business that it has assumed the risk.

(c) If, after delivery of any such evidence of insurance, there is any change in the identity of the eligible surplus lines insurer, or the proportion of the risk assumed by any nonadmitted insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or any other material change as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or to the original writing
producer an appropriate substitute for or endorsement of the original document accurately showing the current status of the coverage and the insurer responsible thereunder.

(d) Every evidence of insurance negotiated, placed or procured under the provisions of this article issued by the surplus lines licensee shall bear the name of the licensee and the following legend in 10-point type: "The insurer which has issued this insurance is not licensed by the Pennsylvania Insurance Department and is subject to limited regulation. This insurance is NOT covered by the Pennsylvania Property and Casualty Insurance Guaranty Association."


Section 1613. Valid Surplus Lines Insurance.--Contracts of insurance procured under this article shall be valid and enforceable as to all parties. Nothing in this article shall be interpreted to prevent an insured from enforcing his rights under the terms and conditions of a contract of insurance entered into in violation of this article.

(1613 added Dec. 18, 1992, P.L.1519, No.178)

Section 1614. Effect of Payment to Surplus Lines Licensee.--A payment of premium to the writing producer or to a surplus lines licensee acting for a person other than himself in negotiating, continuing or reviewing any contract of insurance under this article shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the contract notwithstanding.


Section 1615. Licensing of Surplus Lines Licensee.--(a) For insureds whose home state is this Commonwealth, no insurance producer licensed by the department shall transact surplus lines insurance with any nonadmitted insurer unless the insurance producer possesses a valid surplus lines producer's license issued by the department. ((a) amended June 30, 2011, P.L.194, No.28)

(b) The department shall issue a surplus lines producer's license to any resident of this Commonwealth or to a nonresident who is a qualified holder of a current Pennsylvania property and casualty insurance producer's license, but only when the insurance producer has complied with the following:

(1) Remitted the surplus lines producer license fee to the department.

(2) Submitted a properly completed surplus lines producer license application on a form supplied by the department.

(3) Passed a qualifying examination approved by the department, except that all holders of a license prior to the effective date of this article shall be deemed to have passed such an examination.

(c) Business entities that are licensed as Pennsylvania insurance producers shall be eligible to be surplus lines licensees if the business entities do all of the following:

(1) Designate one or more officers or partners licensed under this article to be responsible for compliance with all reporting and recordkeeping required by this article.

(2) Provide to the department a list of all surplus lines licensees associated with and placing surplus lines business through the business entity. The business entity shall provide to the department an updated list of licensees within five (5) business days of a change in association of any licensee. The list shall be available at all times for inspection by the department.

(c.1) A nonresident person whose home state issues surplus lines licenses to residents of Pennsylvania on the same basis
and who is licensed in Pennsylvania as a property and casualty producer may be licensed as a surplus lines producer if the person does all of the following:

1. Is currently licensed as a surplus lines producer and is in good standing in its home state.
2. Has submitted a complete application for a surplus lines license and has paid the required fees.
3. Has submitted or transmitted to the department the application for a surplus lines license submitted in its home state or a completed uniform application that complies with section 610-A of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."
4. Has complied with all of the provisions of Article VI-A of "The Insurance Department Act of 1921."

(c.2) The commissioner may participate with the National Association of Insurance Commissioners or its affiliates in a centralized insurance producer registry for the purpose of submitting or obtaining information on insurance producers, surplus lines producers and other licensees, including licensing history, lines of authority and regulatory actions. ((c.2) added June 30, 2011, P.L.194, No.28)

(d) Each surplus lines license shall be:

1. Issued as follows:
   \(\text{(i)}\) Only in the name of the individual applicant or business entity. A licensee doing business under a fictitious name other than the name appearing on the license shall be required to notify the department in writing prior to use of the fictitious name for the department's consent to use of the name.
   \(\text{(ii)}\) In paper or electronic form.
   \(\text{(iii)}\) For a period not to exceed two (2) years. The following shall apply:
      \(\text{(A)}\) The surplus lines license of a natural person shall expire on the last day of the birth month of the licensee. The initial license cycle may vary to coincide with the expiration cycle of the birth month.
      \(\text{(B)}\) The surplus lines license of a business entity shall expire on the last day of the month in which the license was originally issued.
2. Nontransferable.
3. A nonrefundable two hundred dollar ($200) fee shall accompany an application or renewal for a surplus lines license, unless modified by the department by regulation.
4. The following shall apply:
   \(\text{(1)}\) A surplus lines licensee that allows the licensee's license to lapse by failing to timely renew the license or by failing to pay the fee required by this act may, within one year of the license renewal date, request the department to reinstate the license. Persons requesting reinstatement shall pay a fee of two times the fee required by this act and may be subject to other penalties as provided by law before the license will be renewed.
   \(\text{(2)}\) Persons requesting reinstatement of a lapsed license shall submit a completed renewal form and the fee required by this act.
   \(\text{(3)}\) The department shall reinstate a license under this subsection retroactively, with the reinstatement effective on the date the license lapsed, if the department receives a request for reinstatement together with a completed renewal application and payment of the lapsed license fee within sixty (60) days after the license lapsed.
   \(\text{(4)}\) The department shall reinstate a license under this subsection prospectively, with reinstatement effective on the
date that the license is reinstated, if the department receives a request for reinstatement of a lapsed license more than sixty (60) days after the license lapsed but within one year after the license lapsed.

(5) If a person applies for reinstatement more than one year after the lapse date, the person must reapply for the license under this act.

(g) As used in subsection (c.i), the term "home state" for an insurance producer or surplus lines producer shall be as defined as in section 601-A of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921." ((g) added June 30, 2011, P.L.194, No.28)


Section 1616. Surplus Lines Licensees May Accept Business from Insurance Producers.--A surplus lines licensee may originate surplus lines insurance or accept such insurance from an insurance producer duly licensed as to the kind or kinds of insurance involved, and the surplus lines licensee may compensate the insurance producer.

(1616 amended June 30, 2011, P.L.194, No.28)

Section 1617. Compliance with Law by Two or More Surplus Lines Licensees.--(a) When two or more surplus lines licensees are involved in a transaction subject to this article, the surplus lines licensee dealing directly with or closest to the insured is responsible for compliance with sections 1604, 1608, 1609, 1612, 1619 and 1621.

(b) This provision shall not serve to relieve any surplus lines licensee involved in any transaction subject to this article from compliance with any other section of this article.

(1617 added Dec. 18, 1992, P.L.1519, No.178)

Section 1618. Surplus Lines Licensee with Binding Authority.--Any surplus lines licensee who is granted binding or underwriting authority by an eligible surplus lines insurer shall be subject to regulations and rules promulgated, from time to time, by the department.

(1618 added Dec. 18, 1992, P.L.1519, No.178)

Section 1619. Records of Surplus Lines Licensee.--(a) Each surplus lines licensee shall keep in its office a full and true record of each surplus lines insurance contract placed by or through it, including a copy of the policy, certificate, cover note or other evidence of insurance, showing such of the following items as may be applicable:

1. Amount of the insurance and perils insured.
2. Brief description of the risk insured and its location.
4. Any return premium paid.
5. Rate of premium charged for each risk insured.
6. Effective date and terms of the contract.
7. Name and address of the insured.
8. Name and address of the eligible surplus lines insurer and any nonadmitted insured involved pursuant to section 1606.
9. Amount of tax and other sums to be collected from the insured.
10. Identity of the writing producer, any confirming correspondence from the insurer or its representative and the application.
11. A copy of the written notice required by section 1608.

(b) The record of each contract shall be kept open at all reasonable times to examination by the department without notice for a period of not less than five (5) years following termination of the contract.
(c) If the surplus lines licensee is a natural person who is associated with a business entity which is a valid surplus lines licensee, the business entity with which the licensee is associated shall retain the records which are required by this section to be kept by each surplus lines licensee.


Section 1620. Monthly Reports.--Within thirty (30) days following the end of each month, each surplus lines licensee shall file with the department, on forms prescribed by the department, a verified report of all surplus lines insurance transacted during the preceding month.


Section 1621. Surplus Lines Tax.--(a) (1) There is hereby levied a tax of three per centum (3%) on all premiums charged for insurance which is placed with either an eligible surplus lines insurer, other than a risk retention group, or other nonadmitted insurer in accordance with this article, such taxes to be based on the gross premiums charged less any return premiums. This tax shall be in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any unearned portion of the premium shall be returned to the insured.

(2) In the event that a placement of insurance involves subjects of insurance resident, located or to be performed in one or more states other than this Commonwealth, then the premium taxes provided for in this section shall be levied:

(i) For policies placed before July 1, 2011, only on that portion of the premium reasonably ascribable to that portion of the risk situated in this Commonwealth.

(ii) For policies placed after June 30, 2011, upon the gross premium charged less any return premiums where this Commonwealth is the home state of the insured.

(b) (b) deleted by amendment)

(c) (c) deleted by amendment)

(d) (d) deleted by amendment)

(d.1) (1) Each surplus lines licensee shall, on or before January 31 of each year, file a report of all premiums transacted from the placement of insurance with either an eligible surplus lines insurer or other nonadmitted insurers during the previous calendar year. The report shall be filed as prescribed by the Department of Revenue with any payment. A full copy of the report shall be filed with the department by the surplus lines licensee.

(2) The report described under this subsection shall set forth the name of the insured, the home state of the insured, if required by the department, identification of the insurer, the type of insurance, gross premiums charged less any return premiums allowed, the tax due as provided in this section and any other information as required by the Department of Revenue. A surplus lines licensee that is a business entity licensee which files the annual premium tax return with the Department of Revenue shall include in its return the premium taxes generated during the year subject to reporting by all licensees associated with said business entity during the reporting period. The report shall be made on forms prescribed by the Department of Revenue.

(3) The remittance for the taxes due shall accompany the report described under this subsection. Neither the surplus lines licensee nor the writing producer shall pay directly or indirectly the tax or any portion of the tax, either as an inducement to the insured to purchase the insurance or for any other reason. The surplus lines licensee shall collect from the
insured or the writing producer the amount of the tax at the
time of delivery of the initial policy, cover note or other
evidence of insurance or at the time thereafter as is reasonably
consistent with normal credit terms customary in the business.

(4) A penalty shall be imposed for failure to file the
report required under this subsection on or before the due date
in accordance with the rules of section 403(d) of the act of
March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of
1971."

(e) With respect to insurance placed with or issued by a
risk retention group which is an eligible surplus lines insurer,
there is hereby levied a tax of two per centum (2%) on all
premiums charged for risks resident, located or to be performed
in this Commonwealth. The risk retention group shall be
responsible for the payment of the taxes levied in this article
in accordance with procedures set forth in Article XV.

(f) The assessment of taxes imposed by this article,
including the granting of extensions of time to file reports
and the rights of the taxpayers to present and prosecute a
petition for assessment, a petition for review or an appeal to
court or to file a petition for refund and the imposition of
interest and penalties, shall be governed by the provisions of
the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform
Code of 1971," as approved in the case of corporate net income
tax.

(1621 amended June 30, 2011, P.L.194, No.28)
Section 1622. Tax on Independently Procured Insurance.--(a)
(1) The tax provided by section 1621(a) is imposed upon an
insured whose home state is this Commonwealth who independently
procures insurance from a nonadmitted insurer or continues or
renews such independently procured insurance.
(2) If the independently procured insurance covers risks
resident, located or to be performed in one or more states other
than this Commonwealth, the premium taxes shall be payable as
computed in accordance with section 1621(a).

(b) The insured shall, within thirty (30) days after the
last day of the month in which the insurance was independently
procured, continued or renewed, report the transaction on the
forms and in the manner prescribed by the Department of Revenue.
The report shall set forth the information required of surplus
lines licensees as required in any report described under
section 1621. The tax of three per centum (3%) shall be paid
on the date the report is due as provided under this section.
The insured shall file a copy of the report with the department
upon its request.

(c) A penalty shall be imposed for failure to file the
report required under this section on or before the due date
in accordance with the rules of section 403(d) of the act of
March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of
1971."

(1622 amended June 30, 2011, P.L.194, No.28)
Section 1623. Suspension, Revocation or Nonrenewal of
Surplus Lines Licensee's License.--The department may suspend,
revoke or refuse to renew the license of a surplus lines
licensee after notice and a hearing, as provided under the
applicable provision of the laws of this Commonwealth, upon any
one or more of the following grounds:
(3) Closing of the surplus lines licensee's office for a
period of more than thirty (30) business days, unless permission
is granted by the department.
(4) Failure to make and file required reports.
(5) Failure to collect or transmit required tax on surplus lines premiums.

(7) Failure to remit premiums due insurers or return premiums due insureds in the normal course of business and within reasonable time limits.

(8) Violation of any provision of this act.

(9) For any other cause for which an insurance producer's license could be denied, revoked or suspended or refused upon renewal.

(1623 amended June 30, 2011, P.L.194, No.28)

Section 1624. Service of Process in Actions Against Surplus Lines Insurer.--(a) An eligible surplus lines insurer may be sued upon any cause of action arising in this Commonwealth under any surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. Service of process shall be made pursuant to the procedures provided by 42 Pa.C.S. Ch. 53 Subch. B (relating to interstate and international procedure). Any such surplus lines insurance contract or evidence of insurance delivered by the surplus lines licensee shall contain a provision stating the substance of this section and designating the person to whom process shall be mailed.

(b) Each nonadmitted insurer accepting surplus lines insurance shall be deemed thereby to have subjected itself to accepting service of process under 42 Pa.C.S. Ch. 53 Subch. B.

(c) The service of process procedures provided in this section are in addition to any other methods provided by law for service of process upon insurers.

(1624 amended July 10, 2002, P.L.749, No.110)

Section 1625. Penalties.--(a) Any surplus lines licensee who, in this Commonwealth, represents or aids a nonadmitted insurer in violation of this article commits a misdemeanor of the third degree and, upon conviction, be sentenced to pay a fine of not more than two thousand ($2,000) dollars.

(b) In addition to any other penalty provided for in subsection (a) or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person violating any provision of this article shall be liable to a civil penalty not exceeding two thousand ($2,000) dollars for the first offense and not exceeding four thousand ($4,000) dollars for each succeeding offense.

(c) The penalties in this section are not exclusive remedies. Penalties may also be assessed under the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act," and any other applicable statute.

(1625 amended Mar. 22, 2010, P.L.147, No.14)

Section 1626. Compliance.--Nothing in this act shall relieve a surplus lines licensee involved in any transaction from compliance with this act or its predecessor acts.

(1626 added Mar. 22, 2010, P.L.147, No.14)

ARTICLE XVII.

LIFE AND HEALTH INSURANCE

GUARANTY ASSOCIATION.

(Art. added Dec. 18, 1992, P.L.1519, No.178)

Section 1701. Purpose.--The purpose of this article is to protect, subject to certain limitations, the persons specified in section 1703(a) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in section 1703(b), because of the impairment or insolvency of the member insurer
that issued the policies or contracts. To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

(1701 added Dec. 18, 1992, P.L.1519, No.178)

Section 1702. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Account." Any of the two accounts created under section 1704.

"Association." The Pennsylvania Life and Health Insurance Guaranty Association created under section 1704.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Contractual obligation." Any obligation under a policy or contract or certificate under a group policy or contract or portion thereof for which coverage is provided under section 1703.

"Covered policy." Any policy or contract within the scope of this article under section 1703.

"Department." The Insurance Department of the Commonwealth.


"Impaired insurer." A member insurer which, after the effective date of this article, is not an insolvent insurer and:

(1) is deemed by the Insurance Commissioner to be potentially unable to fulfill its contractual obligations; or
(2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Insolvent insurer." A member insurer which, after the effective date of this article, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.


"Member insurer." Any insurer licensed or which holds a certificate of authority to transact in this Commonwealth any kind of insurance for which coverage is provided under section 1703 and includes any insurer whose license or certificate of authority in this Commonwealth may have been suspended, revoked, not renewed or voluntarily withdrawn. The term does not include any of the following:

(1) A nonprofit hospital or medical service organization.
(2) A health maintenance organization.
(3) A fraternal benefit society.
(4) A mandatory State pooling plan.
(5) A mutual assessment company or any entity that operates on an assessment basis.
(6) An insurance exchange.
(7) Any entity similar to any of the above.


"Person." Any individual, corporation, partnership, association or voluntary organization.

"Premiums." The amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon and less dividends and experience credits thereon. The term does not include any amounts received for any policies or
contracts or for the portions of any policies or contracts for which coverage is not provided under section 1703(b) except that assessable premium shall not be reduced on account of sections 1703(b)(2)(iii) relating to interest limitations and 1703(c)(1)(ii) relating to limitations with respect to any one individual, any one participant and any one contract holder. The term does not include any premiums in excess of five million ($5,000,000) dollars on any unallocated annuity contract not issued under a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.).

"Resident." Any person who resides in this Commonwealth at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business.

"Supplemental contract." Any agreement entered into for the distribution of policy or contract proceeds.

"Unallocated annuity contract." Any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

(1702 added Dec. 18, 1992, P.L.1519, No.178)

Section 1703. Coverage and Limitations.--(a) This article shall provide coverage to the following persons for the policies and contracts specified in subsection (b):

(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under paragraph (2).

(2) To persons who are owners of or certificate holders under these policies or contracts or, in the case of unallocated annuity contracts, to the persons who are the contract holders and who:

(i) are residents; or

(ii) are not residents, but only under all of the following conditions:

(A) the insurers which issued such policies or contracts are domiciled in this Commonwealth;

(B) such insurers never held a license or certificate of authority in the states in which such persons reside;

(C) these states have associations similar to the association created by this article; and

(D) these persons are not eligible for coverage by those associations.

(b) (1) This article shall provide coverage to the persons specified in subsection (a) for direct, nongroup life, health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts and for unallocated annuity contracts issued by member insurers, except as limited by this article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(2) This article shall not provide coverage for any of the following:
(i) Any portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract holder.

(ii) Any policy or contract of reinsurance, unless assumption certificates have been issued.

(iii) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) averaged over the period of four (4) years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the association became obligated; and

(B) on and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available.

(iv) Any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under:

(A) a Multiple Employer Welfare Arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan;

(D) an administrative services only contract.

(v) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits or provides that any fees or allowances to be paid to any person, including the policyholder or contract holder, in connection with the service to or administration of such policy or contract.

(vi) Any policy or contract issued in this Commonwealth by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract.

(vii) Any unallocated annuity contract issued to an employee benefit plan protected under the Federal Pension Benefit Guaranty Corporation.

(viii) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery.

(c) (1) The benefits for which the association may become liable shall in no event exceed the lesser of:

(i) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(ii) (A) With respect to any one life, regardless of the number of policies or contracts, the following shall apply:

(I) Three hundred thousand ($300,000) dollars in life insurance death benefits, but not more than one hundred thousand ($100,000) dollars in net cash surrender and net cash withdrawal values for life insurance.

(II) Three hundred thousand ($300,000) dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values.
(III) Three hundred thousand ($300,000) dollars in annuity benefits, including one hundred thousand ($100,000) dollars in net cash surrender and net cash withdrawal values.
(IV) Three hundred thousand ($300,000) dollars in long-term care insurance benefits, as defined under section 1103, including any cash surrender and net cash withdrawal values.
(B) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code of 1986 covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, three hundred thousand ($300,000) dollars in annuity benefits, including one hundred thousand ($100,000) dollars in net cash surrender and net cash withdrawal values.
(C) With respect to any one contract holder covered by any unallocated annuity contract not included in clause (B), five million ($5,000,000) dollars in benefits, irrespective of the number of such contracts held by that contract holder.
(2) The association shall not, however, be liable to expend more than three hundred thousand ($300,000) dollars in the aggregate with respect to any one individual under subparagraph (ii)(A) and (B) of paragraph (1).

(1703 amended July 17, 2007, P.L.134, No.40)

Compiler's Note: Section 6 of Act 40 of 2007, which amended section 1703, provided that the amendment of subsec. (c)(1)(ii)(A)(II) and (IV) shall apply to insolvency occurring on or after the effective date of section 6.

Section 1704. Creation of Association.--(a) There is hereby created a nonprofit, unincorporated association to be known as the Pennsylvania Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this Commonwealth. The association shall perform its functions under the plan of operation established and approved under section 1708 and shall exercise its powers through a board of directors established under section 1705. For purposes of administration and assessment the association shall maintain two accounts:
(1) The life insurance and annuity account which includes the following subaccounts:
   (i) Life insurance account.
   (ii) Annuity account.
   (iii) Unallocated annuity account which shall include contracts qualified under section 403(b) of the Internal Revenue Code of 1986.
(2) The health insurance account.
(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this Commonwealth. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.
(1704 added Dec. 18, 1992, P.L.1519, No.178)

Section 1705. Board of Directors.--(a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the
commissioner. To select the initial board of directors and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer shall be entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

(1705 added Dec. 18, 1992, P.L.1519, No.178)

Section 1706. Powers and Duties of Association.--(a) If a member insurer is an impaired domestic insurer, the association may, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer that are approved by the commissioner and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured any or all of the policies or contracts of the impaired insurer;

(2) provide such moneys, pledges, notes, guarantees or other means as are proper to effectuate paragraph (1) and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (1); or

(3) loan money to the impaired insurer.

(b) (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in paragraph (2), the association shall, in its discretion, either:

(i) take any of the actions specified in subsection (a), subject to the conditions therein; or

(ii) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(2) The association shall be subject to the requirements of paragraph (1) only if:

(i) the laws of its state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(A) the delinquency proceeding shall not be dismissed;

(B) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;

(C) it shall not be permitted to solicit or accept new business or have any suspended or revoked license restored;
(ii) in the case where the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this Commonwealth; or

(iii) in the case where the impaired insurer is a foreign or alien insurer, it has been prohibited from soliciting or accepting new business in this Commonwealth, its certificate of authority has been suspended or revoked in this Commonwealth, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

(c) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured the policies or contracts of the insolvent insurer;

(2) assure payment of the contractual obligations of the insolvent insurer and provide such moneys, pledges, guarantees or other means as are reasonably necessary to discharge such duties; or

(3) with respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (d).

(d) (1) When proceeding under subsection (b)(1)(ii) or (c)(3), the association shall, with respect to only life and health insurance policies, do all of the following:

(i) Assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred as follows:

(A) With respect to group policies, not later than the earlier of the next renewal date under such policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to such policies.

(B) With respect to individual policies, not later than the earlier of the next renewal date (if any) under such policies or one year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to such policies.

(ii) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty (30) days notice of the termination of the benefits provided.

(iii) With respect to individual policies, make available to each known insured or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph (2), if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(2) (i) In providing the substitute coverage required under paragraph (1)(iii), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.
(iii) The association may reinsure any alternative or reissued policy.

(3) (i) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this Commonwealth and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(4) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(5) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured or the association.

(e) When proceeding under subsection (b)(1)(ii) or (c) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 1703(b)(2)(iii).

(f) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy or coverage under this article with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(g) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(h) The protection provided by this article shall not apply where any guaranty protection is provided to residents of this Commonwealth by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this Commonwealth.

(i) In carrying out its duties under subsections (b) and (c) and subject to approval by the court, the association may do the following:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this
act or that the economic or financial conditions as they affect
member insurers are sufficiently adverse to render the
imposition of such permanent policy or contract liens to be in
the public interest.

(2) Impose temporary moratoriums or liens on payments of
cash values and policy loans, or any other right to withdraw
funds held in conjunction with policies or contracts, in
addition to any contractual provisions for deferral of cash or
policy loan value.

(j) If the association fails to act within a reasonable
period of time as provided in subsections (b)(1)(ii), (c) and
(d), the commissioner shall have the powers and duties of the
association under this article with respect to impaired or
insolvent insurers.

(k) The association may render assistance and advice to the
commissioner, upon his request, concerning rehabilitation,
payment of claims, continuance of coverage or the performance
of other contractual obligations of any impaired or insolvent
insurer.

(l) The association shall have standing to appear before
any court in this Commonwealth with jurisdiction over an
impaired or insolvent insurer concerning which the association
is or may become obligated under this article. Such standing
shall extend to all matters germane to the powers and duties
of the association, including, but not limited to, proposals
for reinsuring, modifying or guaranteeing the policies or
contracts of the impaired or insolvent insurer and the
determination of the policies or contracts and contractual
obligations. The association shall also have the right to appear
or intervene before a court in another state with jurisdiction
over an impaired or insolvent insurer for which the association
is or may become obligated or with jurisdiction over a third
party against whom the association may have rights through
subrogation of the insurer's policyholders.

(m) (1) Any person receiving benefits under this article
shall be deemed to have assigned the rights under and any causes
of action relating to the covered policy or contract to the
association to the extent of the benefits received because of
this article, whether the benefits are payments of or on account
of contractual obligations, continuance of coverage or provision of substitute or alternative coverages. The
association may require an assignment to it of such rights and
cause of action by any payee, policy or contract owner,
beneficiary, insured or annuitant as a condition precedent to
the receipt of any rights or benefits conferred by this article
upon such person.

(2) The subrogation rights of the association under this
subsection shall have the same priority against the assets of
the impaired or insolvent insurer as that possessed by the
person entitled to receive benefits under this article.

(n) The association may do the following:

(1) Enter into such contracts as are necessary or proper
to carry out the provisions and purposes of this article.

(2) Sue or be sued, including taking any legal actions
necessary or proper to recover any unpaid assessments under
section 1707 and to settle claims or potential claims against
it.
(3) Borrow money to effect the purposes of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association and perform such other functions as become necessary or proper under this article.

(5) Take such legal action as may be necessary to avoid payment of improper claims.

(6) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this article.

(o) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(1706 added Dec. 18, 1992, P.L.1519, No.178)

Section 1707. Assessments.--(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight per centum (8%) per annum on and after the due date.

(b) There shall be two assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of section 1710(e). Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 1706 with regard to an impaired or an insolvent insurer.

(c) (1) The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed two hundred ($200) dollars per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this Commonwealth by each assessed member insurer for policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this Commonwealth for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this article. Classification of assessments under subsection
(b) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e) (1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one (1) calendar year exceed two per centum (2%) and for the health account shall not in any one (1) calendar year exceed two per centum (2%) of such insurer's average premiums received in this Commonwealth on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If a one per centum (1%) assessment for any subaccount of the life and annuity account in any one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (c)(2), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (e)(1).

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article, provided that such insurer has not elected to take tax credits as provided in section 1711(a).

(h) The association shall issue to each insurer paying an assessment under this article, other than class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.
Section 1708. Plan of Operation.--(a) (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he has not disapproved it within thirty (30) days.

(2) If the association fails to submit a suitable plan of operation within one hundred twenty (120) days following the effective date of this article or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this article, contain the following:

(1) Establish procedures for handling the assets of the association.

(2) Establish the amount and method of reimbursing members of the board of directors under section 1705.

(3) Establish regular places and times for meetings, including telephone conference calls of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors.

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner.

(6) Establish any additional procedures for assessments under section 1707.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under sections 1706(n)(3) and 1707, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

Section 1709. Powers and Duties of the Commissioner.--(a) In addition to the powers and duties enumerated elsewhere in this article, the commissioner shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time;
(1) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this Commonwealth of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five per centum (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred ($100) dollars per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty (60) days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this article.

(1709 added Dec. 18, 1992, P.L.1519, No.178)

Section 1710. Prevention of Insolvencies.--(a) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(i) revocation of license;

(ii) suspension of license; or

(iii) makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the Commonwealth, reinsure all or any part of its business or increase capital, surplus or any other account for the security of policyholders or creditors.

This notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.

(2) To report to the board of directors when he has taken any of the actions set forth in paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company that such company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the National Association of Insurance Commissioners' (NAIC) Insurance Regulatory Information System (IRIS) ratios and listing of
companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this Commonwealth.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this Commonwealth. Such reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) (1) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association, and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (a).

(2) The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.

(1710 added Dec. 18, 1992, P.L.1519, No.178)

Section 1711. Credits for Assessments Paid.--(a) A member insurer may offset against its premium tax liability to this Commonwealth a proportionate part of the assessments described in section 1707 to the extent of twenty per centum (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid. In
the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) The proportionate part of an assessment which may be offset against a member company's premium tax liability to the Commonwealth shall be determined according to a fraction of which the denominator is the total premiums received by the company during the calendar year immediately preceding the year in which the assessment is paid and the numerator is that portion of the premiums received during such year on account of policies of life or health and accident insurance in which the premium rates are guaranteed during the continuance of the respective policies without a right exercisable by the company to increase said premium rates.

(c) Any sums which are acquired by refund, pursuant to section 1707(f), from the association by member insurers, and which have theretofore been offset against premium taxes as provided in this section and are not then needed for the purposes of this act, shall be paid by such insurers to this Commonwealth in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

(d) No offset against premium tax liability shall be permitted to the extent that a member insurer's rates or policyholder dividends have been adjusted as permitted in section 1707.

(1711 added Dec. 18, 1992, P.L.1519, No.178)

Section 1712. Miscellaneous Provisions.--(a) Nothing in this article shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 1706. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 1713.

(c) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 1706. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership
rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 1706 with respect to such insurer have been fully recovered by the association.

(e) (1) If an order for liquidation or rehabilitation of an insurer domiciled in this Commonwealth has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4).

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) is insolvent, all its affiliates that controlled it at the time distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(1712 added Dec. 18, 1992, P.L.1519, No.178)

Section 1713. Examination of the Association and Annual Report.--The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

(1713 added Dec. 18, 1992, P.L.1519, No.178)

Section 1714. Tax Exemptions.--The association shall be exempt from payment of all fees and all taxes levied by this Commonwealth or any of its subdivisions, except taxes levied on real property.

(1714 added Dec. 18, 1992, P.L.1519, No.178)

Section 1715. Immunity.--There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employes, the association or its agents or employes, members of the board of directors or the commissioner or his representatives for any action or omission by them in the performance of their powers and duties under this article. Such immunity shall extend to the participation in any organization of one or more other state
associations of similar purposes and to any such organization and its agents or employes.

(1715 added Dec. 18, 1992, P.L.1519, No.178)

Section 1716. Stay of Proceedings and Reopening Default Judgments.--All proceedings in which the insolvent insurer is a party in any court in this Commonwealth shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

(1716 added Dec. 18, 1992, P.L.1519, No.178)

Section 1717. Prohibited Advertisement or Insurance Guaranty Association Act in Insurance Sales.--(a) No person, including an insurer, agent or affiliate of an insurer, shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by this article, provided, however, that this section shall not apply to the association or any other entity which does not sell or solicit insurance.

(b) Within one hundred eighty (180) days of the effective date of this article, the association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subsection (c). This document should be submitted to the commissioner for approval. Sixty (60) days after receiving such approval, no insurer may deliver a policy or contract described in section 1703(b)(1) to a policyholder or contract holder, unless the document is delivered to the policyholder or contract holder prior to or at the time of delivery of the policy or contract except if subsection (d) applies. The document should also be available upon request by a policyholder. The distribution, delivery or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder or insured any greater rights than those stated in this article.

(c) The document prepared under subsection (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a regulation establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the association and department.

(2) Prominently warn the policyholder or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this Commonwealth.

(3) State that the insurer and its agents are prohibited by law from using the existence of the association for the
purpose of sales, solicitation or inducement to purchase any form of insurance.

(4) Emphasize that the policyholder or contract holder should not rely on coverage under the association when selecting an insurer.

(5) Provide other information as directed by the commissioner.

(d) No insurer or agent may deliver a policy or contract described in section 1703(b)(1) and excluded under section 1703(b)(2) from coverage under this article unless the insurer or agent, prior to or at the time of delivery, gives the policyholder or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by regulation specify the form and content of the notice.

(1717 added Dec. 18, 1992, P.L.1519, No.178)

Section 1718. Prospective Application.--This article shall not apply to any insurer which was declared insolvent before the effective date of this article.

(1718 added Dec. 18, 1992, P.L.1519, No.178)

ARTICLE XVIII.

PENNSYLVANIA
PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION.
(Art. added Dec. 12, 1994, P.L.1005, No.137)

Section 1801. Purpose.--The purposes of this article are as follows:

(1) To provide a means for the payment of covered claims under certain property and casualty insurance policies, to avoid excessive delay in the payment of such claims and to avoid financial loss to claimants or policyholders as a result of the insolvency of an insurer.

(2) To assist in the detection and prevention of insurer insolvencies.

(3) To provide for the formulation and administration by the Pennsylvania Property and Casualty Insurance Guaranty Association of a plan of operation necessary to effectuate the provisions of this article.

(1801 added Dec. 12, 1994, P.L.1005, No.137)

Section 1802. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Account." Either of the two accounts provided for under section 1808(a).


"Commissioner." The Insurance Commissioner of the Commonwealth.

"Covered claim." "

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this article applies issued by an insurer if such insurer becomes an insolvent insurer after the effective date of this article and:

(i) the claimant or insured is a resident of this Commonwealth at the time of the insured event: Provided, That for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or
the property from which the claim arises is permanently located in this Commonwealth.

(2) The term shall not include any amount awarded as punitive or exemplary damages; sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool or underwriting association as subrogation recoveries or otherwise.

(3) The term shall not include any first-party claim by an insured whose net worth exceeds twenty-five million ($25,000,000) dollars on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer: Provided, That an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

"Department." The Insurance Department of the Commonwealth.

"Exhaust." The term, with respect to other insurance, means obtaining the maximum limit under the policy. The term, with respect to another insurance guaranty association or its equivalent, means obtaining the statutory limit of recovery or a final judgment from a court of competent jurisdiction determining the amount of the claim payable by the other insurance guaranty association or its equivalent.

"Insolvent insurer." An insurer licensed to transact insurance in this Commonwealth, either at the time the policy was issued or when the insured event occurred, and against whom an order of liquidation with a finding of insolvency has been entered after the effective date of this article by a court of competent jurisdiction in the insurer's state of domicile or of this Commonwealth and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

"Insurer" or "member insurer." Any insurance company, association or exchange which is licensed to write and is engaged in writing within this Commonwealth, on a direct basis, property and casualty insurance policies.

"Net direct written premiums." Direct gross premiums written in this Commonwealth on property and casualty insurance policies, including policies issued to self-insurers, whether or not designated as reinsurance contracts, less return premiums thereon and dividends paid or credited to policyholders of such policies, but does not include premiums on contracts between insurers or reinsurers.

"Person." An individual, a corporation, a partnership, an association or any other holder of or claimant under a property and casualty insurance policy.

"Property and casualty insurance policy." Any contract, including any endorsement, rider, binder (written or oral), cover note, certificate or other instrument of insurance attached or relating thereto, without regard to the nature of the form of the same, which provides any of the coverages enumerated in section 202, except:

(1) Life, annuity, health or disability insurance.

(2) Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks.

(3) Fidelity or surety bonds or any other bonding obligations.

(4) Credit insurance, vendors' single interest insurance or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction.

(5) Insurance of warranties or service contracts.

(6) Title insurance.
(7) Ocean marine insurance.

(8) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.

(9) Any insurance provided by or guaranteed by government.

(10) Workmen's compensation and employer's liability insurance.

(1802 amended Dec. 21, 1995, P.L.714, No.79)

Section 1803. Pennsylvania Property and Casualty Insurance Guaranty Association.--(a) Every insurer shall participate in the Pennsylvania Property and Casualty Insurance Guaranty Association, as hereinafter described, as a condition of its authority to write property and casualty insurance policies within this Commonwealth.

(b) The association shall have the following powers and duties:

(1) (i) To be obligated to pay covered claims existing prior to the determination of the insolvent, arising within thirty (30) days after the determination of insolvent or before the policy expiration date if less than thirty (30) days after the determination of insolvent or before the insured replaces the policy or causes its cancellation if he does so within thirty (30) days of the determination. Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation or the applicable policy limit. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(A) An amount not exceeding ten thousand ($10,000) dollars per policy for a covered claim for the return of unearned premium.

(B) An amount not exceeding three hundred thousand ($300,000) dollars per claimant for all other covered claims.

(ii) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this article, a covered claim shall not include any claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(2) To be deemed the insurer to the extent of its obligation on the covered claims and, to such extent, shall have all rights, duties and obligations of the insolvent insurer as if that insurer had not become insolvent.

(3) To assess member insurers in accordance with sections 1808 through 1811 the amounts necessary to pay the obligations of the association under paragraph (1), the expenses of handling covered claims, the cost of examinations under sections 1805 and 1812(a)(3) and other expenses authorized by this article.

(4) To investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims, and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(5) To give such notice as the commissioner may direct under section 1812(b)(1).
(6) To handle claims through its employees or through one or more of its member insurers which agrees to do so or through other persons designated with the prior approval of the commissioner as servicing facilities.

(7) To reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and pay such other expenses of the association as are authorized by this article.

(8) To notify the commissioner of any information indicating any member insurer may be insolvent or in such condition that its further transaction of business will be hazardous to its policyholders, to its creditors or to the public.

(9) Within ninety (90) days of the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, to prepare a report on the history and causes of such insolvency based on the information available to the association and submit such report to the commissioner.

((b) amended Dec. 21, 1995, P.L.714, No.79)

(c) The association may:

(1) Employ or retain such persons as are necessary to perform the duties of the association.

(2) Borrow funds necessary to effect the purposes of this article in accordance with the plan of operation approved by the commissioner pursuant to section 1804.

(3) Sue or be sued.

(4) Negotiate and become, with the prior approval of the commissioner, a party to such contracts as are necessary to carry out the purposes of this article.

(5) Request that the commissioner order an examination of any member insurer which it in good faith believes may be in such condition that its further transaction of business will be hazardous to its policyholders, to its creditors or to the public.

(6) Make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(7) Make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(8) Perform such other acts as are necessary or proper to effectuate the purposes of this article.

(d) (1) Within ninety (90) days following the effective date of this article, the association shall submit to the commissioner for his review a proposed plan of operation which shall provide for the fair, reasonable and equitable administration of the association, consistent with the purposes and provisions of this article.

(2) The plan of operation shall be subject to and take effect upon approval by the commissioner. If the commissioner disapproves the proposed plan of operation, the association shall, within such period of time as shall be specified by the commissioner, submit for review an appropriately revised plan of operation. If the association fails to do so or if the revised plan so filed is unacceptable, the commissioner shall promulgate a plan of operation.

(e) (1) The association shall be governed by a board of seven directors, serving terms as established in the plan of operation. The members of the board shall be selected by the member insurers, subject to the approval of the commissioner.
(2) Any vacancy on the board shall be filled for the remaining period of the term in the same manner as the initial selections.

(3) If the member insurers fail to select the required number of directors within thirty (30) days after the effective date of this article or if a vacancy remains unfilled for more than fifteen (15) days, the commissioner may appoint the directors necessary to constitute a full board.

(4) In approving selections for the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(5) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them as such members.

(1803 added Dec. 12, 1994, P.L.1005, No.137)

Section 1804. Plan of Operation.--(a) The plan of operation shall establish the procedures for the performance of all the powers and duties of the association provided under section 1803, including, but not limited to, the establishment of:

(1) Procedures for handling assets of the association.

(2) Procedures by which claims may be filed with the association and the specification of acceptable forms of proof of covered claims.

(3) Procedures for records to be kept of all financial transactions of the association.

(b) The plan of operation may provide that any or all powers and duties of the association except those provided under section 1803(b)(3) and (c)(2) may be delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association or its equivalent in two or more states. Such a corporation, association or organization shall be reimbursed on the same basis as would a servicing facility and shall be compensated for the performance of any other functions delegated to it by the association. Any delegation under this subsection shall take effect only upon the approval of both the board of directors and the commissioner and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

(c) The plan of operation may be amended by the association, subject to prior approval by the commissioner, or, at the direction of the commissioner, the association shall amend the plan of operation.

(1804 added Dec. 12, 1994, P.L.1005, No.137)

Section 1805. Examination of Association.--The operations of the association shall at all times be subject to the supervision and regulation of the commissioner. The commissioner or any person designated by him shall have the power of visitation of and examination into such operations at any time in the discretion of the commissioner. In connection therewith, the commissioner shall have the powers granted to him by section 216 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921," and the expenses of such examination shall be borne and paid as in that section.

(1805 added Dec. 12, 1994, P.L.1005, No.137)

Section 1806. Annual and Other Statements.--The association shall file with the commissioner, not later than March 30 of each year, a statement which shall contain information with respect to its condition, operations and affairs during the preceding year. This statement shall contain such matters and information as are prescribed by the commissioner, who may at any time require the association to furnish him with additional
Section 1806. Notice to Insurers. -- The association shall be made aware of any information with respect to its condition, operations and affairs or any matter connected therewith which he considers to be material and which will assist him in evaluating its operation.

(1806 added Dec. 12, 1994, P.L.1005, No.137)

Section 1807. Limitation on Taxability of Association.--The association shall be exempt from the payment of all fees and all taxes levied or assessed by the Commonwealth or any of its political subdivisions except taxes upon the real or personal property of the association.

(1807 added Dec. 12, 1994, P.L.1005, No.137)

Section 1808. Assessments.--(a) For purposes of assessment, the association shall be divided into two accounts: (1) an automobile or motor vehicle insurance account; and (2) an account for all other insurance to which this article applies. Subsequent to an insurer having been determined to be an insolvent insurer, the association shall allocate between the two accounts and assess member insurers separately for each account such amounts as are necessary for the purpose of paying the obligations of the association under section 1803(b)(1)(i) and the expenses of handling covered claims of the insolvent insurer. The association shall also assess member insurers for the expenses of examinations under sections 1805 and 1812(a)(3) and for any other expenses authorized by this article.

(b) The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in an account bears to the aggregate net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in such account.

(c) Each member insurer shall be notified of any assessment not later than thirty (30) days before it is due.

(d) No member insurer may be assessed in any year on an account an amount greater than two per centum (2%) of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account.

(e) If the maximum assessments of all member insurers on an account, together with the other assets of the association in the account, do not provide in any one year an amount sufficient to meet all obligations of the association under that account, the funds available shall be prorated among such obligations, and the unpaid portions of the same shall be paid as soon thereafter as funds become available.

(f) The association may, in whole or in part, exempt from assessment any member insurer or defer the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance.

(1808 added Dec. 12, 1994, P.L.1005, No.137)

Section 1809. Refunds.--The association may refund to its member insurers in proportion to the contribution of each to an account of the association that amount, if any, by which the assets of the account at the end of any calendar year exceed its estimated liabilities for the coming year.

(1809 added Dec. 12, 1994, P.L.1005, No.137)

Section 1810. Recognition of Assessments in Rates.--The rates and premiums charged by a member insurer for policies to which this article applies shall appropriately reflect assessments paid to the association by the member insurer less any amounts returned to the member insurer by the association.
Section 1811. Nature of Assessments.--Assessments made by an insurance guaranty association or similar entities pursuant to the laws of any other state shall not be considered "burdens or prohibitions" under section 212 of the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of 1921."

Section 1812. Powers and Duties of Commissioner.--(a) The commissioner shall:
(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency. The association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction.
(2) Upon request of the association, provide it with a statement of the net direct written premiums of each member insurer.
(3) Begin an examination of a member insurer within thirty (30) days of receipt of a request by the association for such examination pursuant to section 1803(c)(5). The expenses of any such examination shall be paid by the association.

(b) The commissioner may:
(1) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this article. Such notification shall be by mail at their last known address and by publication in such newspapers of general circulation as the commissioner shall specify.
(2) After notice and hearing, suspend or revoke the certificate of authority to transact insurance in this Commonwealth of any member insurer or levy a penalty payable to the Commonwealth upon any such insurer which:
   (i) fails to pay an assessment when due and after demand having been made; or
   (ii) otherwise fails to comply with the plan of operation. The penalty levied hereunder for failure to pay an assessment when due shall be not less than one hundred ($100) dollars per month nor more than five per centum (5%) of such unpaid assessment per month. The penalty for otherwise failing to comply with the plan of operation shall be not less than one hundred ($100) dollars nor more than one thousand ($1,000) dollars per month for each month that such insurer continues after notice having been given to fail to comply with the plan of operation.
(3) Revoke the approval of any servicing facility designated pursuant to section 1803(b)(6) if he finds that claims are not being handled satisfactorily.

Section 1813. Review.--All hearings held by and all orders and decisions made by the commissioner pursuant to this article shall be subject to the provisions of 2 Pa.C.S. (relating to administrative law and procedure), including the provisions in that title for judicial review.

Section 1814. Other Powers and Duties of Commissioner not Limited.--The powers and duties of the commissioner as set forth in this article are in addition to and not in limitation of any other powers and duties of the commissioner as prescribed by law.
Section 1815. Notice of Claims.--Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent, and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

Section 1816. Effect of Paid Claims.--(a) Any person recovering from the association under this article shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this article shall cooperate with the association to the same extent as such person would have been required by the policy under which the claim arises to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims by the association shall not operate to reduce the liability of insureds to the receiver or liquidator for unpaid assessments.

(b) The association shall have the right to recover from the following person the amount of any "covered claim" paid on behalf of such person pursuant to this article:

1. any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds fifty million ($50,000,000) dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article; and

2. any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article.

(c) The receiver or liquidator of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this article against the assets of the insolvent insurer. The expenses of the association or similar organization in another state in handling claims shall be accorded the same priority as the expenses of the receiver or liquidator.

(d) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 1817. Nonduplication of Recovery.--(a) Any person having a claim under an insurance policy shall be required to exhaust first his right under such policy. For purposes of this section, a claim under an insurance policy shall include a claim under any kind of insurance, whether it is a first-party or third-party claim, and shall include, without limitation, accident and health insurance, worker's compensation, Blue Cross and Blue Shield and all other coverages except for policies of an insolvent insurer. Any amount payable on a covered claim under this act shall be reduced by the amount of any recovery under other insurance.
(b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall exhaust first his right of recovery from the association of the place of residence of the insured. Any amount payable on a covered claim under this act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(1817 added Dec. 12, 1994, P.L.1005, No.137)

Section 1818. Immunity.--There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employes, the board of directors or the commissioner or his representatives for any action taken by any of them in the performance of their respective powers and duties under this article.

(1818 added Dec. 12, 1994, P.L.1005, No.137)

Section 1819. Stay of Proceedings and Reopening of Default Judgments.--(a) All proceedings in which the insolvent insurer is party or is obligated to defend a party in any court in this Commonwealth shall be stayed for ninety (90) days from the date the insolvency is determined to permit proper defense by the association of all pending causes of action.

(b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict or finding set aside by the same court that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits.

(1819 added Dec. 12, 1994, P.L.1005, No.137)

Section 1820. Advertising Reference to Association Prohibited.--No member insurer shall, directly or indirectly, make, publish or place before the public in a newspaper or other publication or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station or in any other way an advertisement, announcement or statement of any sort containing any reference to the coverage of the association.

(1820 added Dec. 12, 1994, P.L.1005, No.137)

ARTICLE XX.
AUTOMOBILE INSURANCE ISSUANCE, RENEWAL, CANCELLATION AND REFUSAL.

Section 2001. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Affiliated insurer." An insurer that is an affiliate as defined in section 1401. (Def. added Oct. 22, 2014, P.L.2893, No.183)

"Commissioner." The Insurance Commissioner of this Commonwealth.

"Insurer." An insurance company, association or exchange authorized to transact the business of automobile insurance in this Commonwealth.

"Nonpayment of premium." Failure of the named insured to discharge when due any obligation in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its
agent or indirectly under any premium finance plan or extension or credit.

"Policy of automobile insurance" or "policy." A policy delivered or issued for delivery in this Commonwealth insuring a natural person as named insured or one or more related individuals resident of the same household and under which the insured vehicles therein designated are of the following types only:

(i) a motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers and is not rented to others; or

(ii) any other four-wheel motor vehicle with a gross weight not exceeding nine thousand pounds which is not principally used in the occupation, profession or business of the insured other than farming.

"Renewal" or "to renew." To issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same insurer or affiliated insurer and which provides types and limits of coverage at least equal to those contained in the policy being superseded, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy being extended: Provided, however, That any policy with a policy period or term of less than twelve (12) months or any period with no fixed expiration date shall for the purpose of this article be considered as if written for successive policy periods or terms of twelve (12) months. (Def. amended Oct. 22, 2014, P.L.2893, No.183)


Section 2002. Applicability.--(a) This article shall apply only to:

(1) that portion of a policy of automobile insurance providing bodily injury and property damage liability, comprehensive and collision coverages; and

(2) to the policy's provisions, if any, relating to medical payments and uninsured motorists coverage.

(b) This article shall not apply to:

(1) any policy issued under an automobile assigned risk plan;

(2) any policy insuring more than four automobiles; or

(3) any policy covering garage, automobile sales agency repair shop, service station or public parking place operation hazards.

(c) Nothing in this article shall apply:

(1) If the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal or has manifested such intention by any other means.

(2) If the named insured has demonstrated by some overt action to the insurer or its agent that he wishes the policy to be cancelled or that he does not wish the policy to be renewed.

(3) To any policy of automobile insurance which has been in effect less than sixty (60) days, unless it is a renewal policy, except that no insurer shall decline to continue in force such a policy of automobile insurance on the basis of the grounds set forth in section 2003(a) and except that if an insurer cancels a policy of automobile insurance in the first sixty (60) days, the insurer shall supply the insured with a written statement of the reason for cancellation.

Section 2003. Discrimination Prohibited.--(a) An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons:

(1) Age.
(2) Residence or operation of a motor vehicle in a specific geographic area.
(3) Race.
(4) Color.
(5) Creed.
(6) National origin.
(7) Ancestry.
(8) Marital status.
(9) Sex.
(10) Lawful occupation, including military service.
(11) The refusal of another insurer to write a policy or the cancellation or refusal to renew an existing policy by another insurer.
(12) Illness or permanent or temporary disability where the insured can medically document that such illness or disability will not impair his ability to operate a motor vehicle. Failure to provide such documentation shall be proper reason for the insurer to amend the policy of the named insured to exclude such disabled insured from coverage under the policy while operating a motor vehicle after the effective date of such policy amendment but shall not be proper reason to cancel or refuse to write or renew the policy. Nothing in this provision shall be construed to effect such excluded individual's eligibility for coverage under the named insured's policy for any injury sustained while not operating a motor vehicle. Illness or permanent or temporary disability on the part of any insured shall not be proper reason for cancelling the policy of the named insured.
(13) Any accident which occurred under the following circumstances:
   (i) automobile lawfully parked (if the parked vehicle rolls from the parked position, then any such accident is charged to the person who parked the automobile);
   (ii) the applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgment against such person;
   (iii) automobile is struck in the rear by another vehicle and the applicant or other resident operator has not been convicted of a moving traffic violation in connection with this accident;
   (iv) operator of the other automobile involved in the accident was convicted of a moving traffic violation and the applicant or resident operator was not convicted of a moving traffic violation in connection with the accident;
   (v) automobile operated by the applicant or any resident operator is struck by a "hit-and-run" vehicle if the accident is reported to the proper authority within twenty-four (24) hours by the applicant or resident operator;
   (vi) accident involving damage by contact with animals or fowl;
   (vii) accident involving physical damage limited to and caused by flying gravel, missiles or falling objects;
   (viii) accident occurring when using automobile in response to any emergency if the operator of the automobile at the time of the accident was a paid or volunteer member of any police or fire department, first aid squad or any law enforcement agency. This exception does not include an accident occurring
after the automobile ceases to be used in response to such emergency; or

(ix) accidents which occurred more than thirty-six (36) months prior to the later of the inception of the insurance policy or the upcoming anniversary date of the policy.

(14) Any claim under the comprehensive portion of the policy unless such loss was intentionally caused by the insured.

(b) An insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the thirty-six-month period prior to the upcoming anniversary date of the policy.

(c) For a period twelve (12) months after notice of termination given to an agent:

(1) An insurer may not cancel or refuse to renew existing policies written through the terminated agent because of such termination except as provided in paragraph (2).

(2) An insurer may cancel or refuse to renew only such policies as could have been cancelled or nonrenewed had the agency relationship continued.

(3) An insurer shall be obligated to pay commissions for such policies that are continued or renewed through the terminated agent except where:

(i) the insurer retained ownership of the expirations of such policies; or

(ii) the agent has misappropriated funds or property of the insurer or has failed to remit to the insurer funds due it promptly upon demand or has been terminated for insolvency, abandonment, gross and wilful misconduct or has had his license suspended or revoked.

(d) Subsequent to the twelve-month period after notice of termination given to an agent, an insurer may not cancel or refuse to renew existing policies written through the terminated agent without offering each such insurance coverage on a direct basis or offering to refer the insured to one or more new agents in the event the terminated agent could not find a suitable insurer acceptable to the policyholder for such business. The offer need not be made if the insurer could have cancelled or nonrenewed the policy had the agency relationship continued. If the insurer retains ownership of the expirations of such policies, the insurer need not offer a new agent.

(e) An insurer may not cancel or refuse to renew a policy of automobile insurance for two or fewer moving violations in any jurisdiction or jurisdictions during a twenty-four-month period when the operator's record indicates that the named insured presently bears five points or fewer, unless:

(1) All five points were incurred from one violation.

(2) The driver's license or motor vehicle registration of the named insured has been suspended or revoked.

(3) If, however, the driver's license has been suspended under 75 Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) and the insurer is able to produce proof that he or she has responded to all citations and paid all fines and penalties imposed under that section and that he or she has done so on or before the termination date of the policy, this suspension shall not be grounds for cancellation or for refusal to renew.

(f) The applicability of subsection (e) to one, other than the named insured, who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer to exclude that individual from coverage under the policy but not for cancelling the policy.
(g) As used in subsection (e), "points" shall mean points as set forth in 75 Pa.C.S. Ch. 15 (relating to licensing of drivers).


Section 2004. Valid Reasons to Cancel Policy.--An insurer may not cancel a policy except for one or more of the following specified reasons:

(1) Nonpayment of premium.
(2) The driver's license or motor vehicle registration of the named insured has been under suspension or revocation during the policy period; the applicability of this reason to one who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer thereafter excluding such individual from coverage under the policy but not for cancelling the policy.
(3) A determination that the insured has concealed a material fact, or has made a material allegation contrary to fact, or has made a misrepresentation of a material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer.


Section 2005. Policy Premium Increases.--(a) An insurer may not increase an individual insured's premium or assess a premium surcharge on the basis of any moving traffic violation records, any revocation or suspension records or any accident records if any of the following occurs:

(1) The insured establishes that the records are erroneous or inaccurate.
(2) The citation is imposed under 75 Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) and the insured is able to produce proof that he or she has responded to the citation and paid the fines and penalties imposed under that section. An increase or surcharge imposed prior to the date when an insured provides this proof shall terminate as of the date the insured responded to the citation which is the subject of the increase or surcharge.
(b) At the time an increase or surcharge is applied, the insurer shall notify the insured that the increase or surcharge will be terminated if the insured is able to provide the insurer with proof that the insured has responded to all citations imposed under 75 Pa.C.S. § 1533 and paid any fines and penalties imposed under that section.
(c) All insurers shall provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of a surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance or as a result of any other factors.


Section 2006. Proper Notification of Intention to Cancel.--A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of the cancellation or refusal to renew. The notice shall:

(1) Be in a form acceptable to the Insurance Commissioner.
(2) State the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation or refusal to renew shall become effective. When the policy is being cancelled or not renewed for the reasons set forth in
section 2004(1) and (2), however, the effective date may be fifteen (15) days from the date of mailing or delivery.

(3) State the specific reason or reasons of the insurer for cancellation or refusal to renew.

(4) Advise the insured of his right to request in writing, within thirty (30) days of the receipt of the notice of cancellation or intention not to renew and of the receipt of the reason or reasons for the cancellation or refusal to renew as stated in the notice of cancellation or of intention not to renew, that the Insurance Commissioner review the action of the insurer.

(5) Either in the notice or in an accompanying statement advise the insured of his possible eligibility for insurance through the automobile assigned risk plan.

(6) Advise the insured that he must obtain compulsory automobile insurance coverage if he operates or registers a motor vehicle in this Commonwealth, that the insurer is notifying the Department of Transportation that the insurance is being cancelled or not renewed and that the insured must notify the Department of Transportation that he has replaced said coverage.

(7) Clearly state that when coverage is to be terminated due to nonresponse to a citation imposed under 75 Pa.C.S. § 1533 (relating to suspension of operating privilege for failure to respond to citation) or nonpayment of a fine or penalty imposed under that section coverage shall not terminate if the insured provides the insurer with proof that the insured has responded to all citations and paid all fines and penalties and that he has done so on or before the termination date of the policy.


Section 2007. Exemption from Liability.--There shall be no liability on the part of and no cause of action of any nature shall arise against the Insurance Commissioner, any insurer, the authorized representatives, agents and employees of either or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to write or renew for any statement made by any of them in complying with this act or for the providing of information pertaining thereto. The insurer must furnish the insured the notification required by the Federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) when such cancellations or refusal to write or renew occur.


Section 2007.1. Coverage obligations of loaner vehicles.--(a) An insurance company authorized to write private passenger automobile insurance within this Commonwealth shall provide, where purchased and within the limits of the insured's policy, primary liability coverage for third-party bodily injury and primary first-party physical damage coverage for a motor vehicle provided by a motor vehicle dealer, when an insured has custody of or is operating that motor vehicle, while a motor vehicle specifically listed or covered under the insured's motor vehicle insurance policy is being transported, serviced, repaired or inspected by the motor vehicle dealer.

(b) An insurance company authorized to do business in this Commonwealth shall provide to a motor vehicle dealer or an agent thereof with custody of or operating a customer's motor vehicle for the purpose of transporting, servicing, repairing or inspecting the vehicle, primary liability coverage for third-party bodily injury and primary first-party physical
damage coverage in the amounts set forth in the customer's private passenger automobile insurance policy.

(c) This section shall apply only to the loan of a motor vehicle by a motor vehicle dealer that occurs without financial remuneration in the form of a fee, rental or lease charge paid directly by the insured operating the motor vehicle. Payments made by a third party to a motor vehicle dealer or similar reimbursements shall not be considered payments directly from the insured operating the motor vehicle.

(d) A change in the coverage of a private passenger automobile insurance policy resulting from this section shall not impact the validity of a waiver, selection of benefits or amount of benefits in that policy, beyond the coverage change as a result of this section. An insurer shall file with the Insurance Department any forms or rates revised as a result of this section, along with certification that the revisions are limited to the compliance with this section. The revisions shall be effective ten (10) days after filing.

(e) As used in this section, the term "motor vehicle dealer" shall have the same meaning as "dealer" as defined in section 2 of the act of December 22, 1983 (P.L.306, No.84), known as the "Board of Vehicles Act." (2007.1 added Dec. 20, 2015, P.L.461, No.84)

Compiler's Note: Section 5 of Act 84 of 2015, which added section 2007.1, provided that the addition of section 2007.1 shall apply to all policies issued or renewed on or after 180 days after the effective date of section 5 of Act 84.

Section 2008. Request for Review.--(a) Any insured may, within thirty (30) days of the receipt by the insured of notice of cancellation or notice of intention not to renew and of the receipt of the reason or reasons for the cancellation or refusal to renew as stated in the notice, request in writing to the Insurance Commissioner that the Insurance Commissioner review the action of the insurer in cancelling or refusing to renew the policy of such insured.

(b) Any applicant for a policy who is refused a policy by an insurer shall be given a written notice of refusal to write by the insurer. The notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within thirty (30) days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that the Insurance Commissioner review the action of the insurer in refusing to write a policy for the applicant.


Section 2009. Review Procedure.--(a) On receipt of a request for review, the Insurance Commissioner shall notify the insurer that a review has been requested. The Insurance Commissioner shall review the matter to determine whether the cancellation or refusal to renew or to write was in violation of this article and shall, within forty (40) days of the receipt of such request, either order the policy written or reinstated or uphold the cancellation or refusal to renew.

(b) After a review of a cancellation of or refusal to renew a policy, if the Insurance Commissioner finds the insurer not to be in violation of this article, the policy shall remain in effect until the date referred to in section 2006(2) or thirty (30) days following the conclusion of the review provided for in subsection (a), whichever is later. Provided, however, for review of cancellations under section 2004(1), the policy shall terminate as of the date provided in the notice under section.
2006(2) unless the policy is reinstated. Nothing in this subsection shall be construed to prevent the insurer, at its discretion, from continuing coverage after the initial review period until such time as the Insurance Commissioner has issued a final order.

(c) After review of a cancellation of or refusal to renew a policy, if the Insurance Commissioner finds the insurer to be in violation of this article and the insurer requests a hearing pursuant to subsection (d), the policy shall remain in effect until such time as the Insurance Commissioner has issued a final order.

(d) If either of the parties shall dispute the Insurance Commissioner's findings, that party shall have the right to a formal hearing. In the event a hearing is requested, the Insurance Commissioner shall issue notice of the hearing which shall state the time and place for the hearing, which shall not be less than thirty (30) days from the date of notice.

(e) At the time and place fixed for the hearing in the notice, the parties shall have an opportunity to be heard.

(f) Upon good cause shown, the Insurance Commissioner shall permit any person to intervene, appear and be heard at the hearing in person or by counsel.

(g) The Insurance Commissioner may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and subpoena witnesses, compel their attendance and require the production of books, papers, records or other documents which he deems relevant to the hearing. The Insurance Commissioner shall cause a record to be kept of all evidence and all proceedings at the hearings.

(h) The insurer shall bear the burden at the hearing to prove that the cancellation or refusal to renew complies with this article. However, if the insured requested the hearing and fails to appear at the time and place for the hearing, the Insurance Commissioner may consider a motion to dismiss and shall not be compelled to take evidence at the scheduled hearing. In addition to any remedy in subsection (i), the Insurance Commissioner shall have the authority to order an insurer to cease and desist from acts constituting a violation of this article.

(i) Following the hearing, the Insurance Commissioner shall issue a written order resolving the factual issues presented at the hearing and stating what remedial action, if any, is required. If the Insurance Commissioner finds that the cancellation or refusal to renew violates this article, then the remedial action ordered by the Insurance Commissioner shall include at least one of the following:

(1) That the insurer reimburse the insured for any increase in the cost of insurance and any short-term cancellation fees which are incurred.

(2) That the insurer reinstate the original policy prospectively.

(3) That if an insurer has elected to continue coverage pursuant to subsection (b), the coverage shall remain in full force and effect under the terms of the policy. Reimbursement shall be in the amount incurred by the insured to secure replacement coverage during the pendency of the hearing process, which cost exceeds the cost which would have been incurred had the policy under review remained in effect. The reimbursement shall be based on the difference of the cost of the policies to the extent that the coverage and limits of the replacement coverage does not exceed the original coverage. The insured shall bear the burden to request reimbursement and prove any
increase in the cost of insurance. In addition, if a prospective reinstatement of the original policy is ordered, then the reinstatement shall take effect on the next policy anniversary date unless the insured requests that the reinstatement take effect at an earlier date.

(j) The Insurance Commissioner shall send a copy of the order to the parties participating in the hearing.

(k) All of the actions which may be performed by the Insurance Commissioner in this section may be performed by the Insurance Commissioner's designated representative.


Section 2010. Regulations.--(a) The Insurance Commissioner shall promulgate rules and regulations necessary for the administration of this article.

(b) The Insurance Commissioner may provide in such rules and regulations for the establishment of a filing fee not exceeding fifteen dollars ($15) to accompany the request for review. Should the Insurance Commissioner decide the appeal in favor of the insured, the filing fee shall be returned immediately and the fee shall be paid by the insurer. No part of the review by the Insurance Commissioner shall be subject to the provisions of 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).


Section 2011. Appeal.--(a) The decision of the Insurance Commissioner shall be subject to appeal in accordance with 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action), but the court hearing an appeal shall not decline to affirm a decision on the ground that the requirements of 2 Pa.C.S. Ch. 5 Subch. A were not fulfilled.

(b) Upon a determination that this article has been violated, the Insurance Commissioner may issue an order requiring the insurer to cease and desist from engaging in such violation.

(c) Whenever a violator fails to comply with an order of the Insurance Commissioner to cease and desist from engaging in such violation, the Insurance Commissioner may cause an action for injunction to be filed in court regardless of whether an insurer is licensed by the Insurance Commissioner.


Section 2012. Information and Report.--Each insurer shall maintain records of the numbers of cancellations and refusals to write or renew policies and the reasons therefor and shall supply this information to the Insurance Commissioner upon his request.


Section 2013. Penalty.--Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars ($5,000).


ARTICLE XXI.
QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION.

(a) Preliminary Provisions.
(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2101. Scope.--This article governs quality health care accountability and protection.
(2101 added June 17, 1998, P.L.464, No.68)
Section 2102. Definitions.—As used in this article, the following words and phrases shall have the meanings given to them in this section:

"Active clinical practice." The practice of clinical medicine by a health care provider for an average of not less than twenty (20) hours per week.

"Ancillary service plans." Any individual or group health insurance plan, subscriber contract or certificate that provides exclusive coverage for dental services or vision services. The term also includes Medicare Supplement Policies subject to section 1882 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ss) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

"Clean claim." A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

"Concurrent utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs during an enrollee's hospital stay or course of treatment and results in a decision to approve or deny payment for the health care service.

"Department." The Department of Health of the Commonwealth.

"Drug formulary." A listing of managed care plan preferred therapeutic drugs.

"Emergency service." Any health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

1. disapproves full or partial payment for a requested health care service;
(2) approves the provision of a requested health care service for a lesser scope or duration than requested; or
(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.
The term does not include a complaint.

"Health care provider." A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

"Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

"Managed care plan." A health care plan that uses a gatekeeper to manage the utilization of health care services, integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:
(1) Section 630.
(2) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."
(3) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."
(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. The term does not include ancillary service plans or an indemnity arrangement which is primarily fee for service.

"Plan." A managed care plan.

"Primary care provider." A health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee, initiates enrollee referral for specialist care and maintains continuity of enrollee care.

"Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Provider network." The health care providers designated by a managed care plan to provide health care services.

"Referral." A prior authorization from a managed care plan or a participating health care provider that allows an enrollee to have one or more appointments with a health care provider for a health care service.

"Retrospective utilization review." A review by a utilization review entity of all reasonably necessary supporting
information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Service area." The geographic area for which the managed care plan is licensed or has been issued a certificate of authority.

"Specialist." A health care provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, has board certification or practices in a licensed specialized area of health care. The term includes a health care provider who is not classified by a plan solely as a primary care provider.

"Utilization review." A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee. The term does not include any of the following:

(1) Requests for clarification of coverage, eligibility or health care service verification.

(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan.

(2102 added June 17, 1998, P.L.464, No.68)

(b) Managed Care Plan Requirements.

(2) Consult with health care providers in active clinical practice regarding professional qualifications and necessary specialists to be included in the plan.

(3) Adopt and maintain a definition of medical necessity used by the plan in determining health care services.

(4) Ensure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services.

(5) Adopt and maintain procedures by which an enrollee can obtain health care services outside the plan's service area.

(6) Adopt and maintain procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the plan's established standards are met, be permitted to receive:

(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the plan.
(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.

(8) Adopt and maintain a complaint process as set forth in subdivision (g).

(9) Adopt and maintain a grievance process as set forth in subdivision (i).

(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).

(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).

(12) Provide a list of health care providers participating in the plan to the department every two (2) years or as may otherwise be required by the department. The list shall include the extent to which health care providers in the plan are accepting new enrollees.

(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the plan.

(2111 added June 17, 1998, P.L.464, No.68)

Section 2112. Financial Incentives Prohibition.--No managed care plan shall use any financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee. Nothing in this section shall be deemed to prohibit a managed care plan from using a capitated payment arrangement or other risk-sharing arrangement.

(2112 added June 17, 1998, P.L.464, No.68)

Section 2113. Medical Gag Clause Prohibition.--(a) No managed care plan may penalize or restrict a health care provider from discussing:

(1) the process that the plan or any entity contracting with the plan uses or proposes to use to deny payment for a health care service;

(2) medically necessary and appropriate care with or on behalf of an enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or

(3) the decision of any managed care plan to deny payment for a health care service.

(b) A provision to prohibit or restrict disclosure of medically necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.

(c) No managed care plan shall terminate the employment of or a contract with a health care provider for any of the following:

(1) Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill
ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.

(2) Filing a grievance pursuant to the procedures set forth in this article.

(3) Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.

(d) Nothing in this section shall:

(1) Prohibit a managed care plan from making a determination not to pay for a particular medical treatment, supply or service, enforcing reasonable peer review or utilization review protocols or making a determination that a health care provider has or has not complied with appropriate protocols.

(2) Be construed as requiring a managed care plan to provide, reimburse for or cover counseling, referral or other health care services if the plan:

(i) objects to the provision of that service on moral or religious grounds; and

(ii) makes available information on its policies regarding such health care services to enrollees and prospective enrollees.

(2113 added June 17, 1998, P.L.464, No.68)

(c) Medical Services.

(2113 added June 17, 1998, P.L.464, No.68)

Section 2116. Emergency Services.--(a) If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary.

(b) For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

(c) For emergency services provided to medical assistance participants, the following provisions shall apply:

(1) The provisions of subsection (b) shall apply to the same services provided to medical assistance participants under

(2) Payment for the services shall be in accordance with the current managed care contracted rates.
(3) Sufficient funds shall be appropriated each fiscal year for payment of the services.
(d) The provisions of subsection (b) shall apply to all group and individual major medical health insurance policies issued by a licensed health insurer.
(2116 amended Oct. 24, 2018, P.L.681, No.103)

Compiler's Note: See section 3 of Act 103 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 2117. Continuity of Care.--(a) Except as provided under subsection (b), if a managed care plan initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to sixty (60) days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.
(b) If the plan terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the plan, the plan shall not be responsible for health care services provided to the enrollee following the date of termination.
(c) If the plan terminates the contract of a participating primary care provider, the plan shall notify every enrollee served by that provider of the plan's termination of its contract and shall request that the enrollee select another primary care provider.
(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.
(e) A plan may require a nonparticipating health care provider whose health care services are covered under this section to meet the same terms and conditions as a participating health care provider.
Nothing in this section shall require a managed care plan to provide health care services that are not otherwise covered under the terms and conditions of the plan.

(2117 added June 17, 1998, P.L.464, No.68)

(d) Provider Credentialing.
(2117 added June 17, 1998, P.L.464, No.68)

Section 2121. Procedures.--(a) A managed care plan shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) The department shall establish credentialing standards for managed care plans. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for managed care plans.

(c) A managed care plan shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) A managed care plan shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the plan's provider network. A managed care plan shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of a managed care plan shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No managed care plan shall exclude or terminate a health care provider from participation in the plan due to any of the following:

1. The health care provider engaged in any of the activities set forth in section 2113(c).
2. The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.
3. The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.
4. If a managed care plan denies enrollment or renewal of credentials to a health care provider, the managed care plan shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

(2121 added June 17, 1998, P.L.464, No.68)

(e) Confidentiality.
(2121 added June 17, 1998, P.L.464, No.68)

Section 2131. Confidentiality.--(a) A managed care plan and a utilization review entity shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis and treatment is adequately protected and remains confidential in compliance with all applicable Federal and State laws and regulations and professional ethical standards.

(b) To the extent a managed care plan maintains medical records, the plan shall adopt and maintain procedures to ensure
that enrollees have timely access to their medical records unless prohibited by Federal or State law or regulation.

(c) (1) Information regarding an enrollee's health or treatment shall be available to the enrollee, the enrollee's designee or as necessary to prevent death or serious injury.

(2) Nothing in this section shall:

(i) Prevent disclosure necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim.

(ii) Deny the department, the Insurance Department or the Department of Public Welfare access to records for purposes of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with this article and other laws of this Commonwealth. Records shall be accessible only to department employees or agents with direct responsibilities under the provisions of this subparagraph.

(iii) Deny access to information necessary for a utilization review entity to conduct a review under this article.

(iv) Deny access to the managed care plan for internal quality review, including reviews conducted as part of the plan's quality oversight process. During such reviews, enrollees shall remain anonymous to the greatest extent possible.

(v) Deny access to managed care plans, health care providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For this purpose, enrollees shall provide consent and shall remain anonymous to the greatest extent possible.

(2131 added June 17, 1998, P.L.464, No.68)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

(f) Information for Enrollees.

(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2136. Required Disclosure.--(a) A managed care plan shall supply each enrollee and, upon written request, each prospective enrollee or health care provider with the following written information. Such information shall be easily understandable by the layperson and shall include, but not be limited to:

(1) A description of coverage, benefits and benefit maximums, including benefit limitations and exclusions of coverage, health care services and the definition of medical necessity used by the plan in determining whether these benefits will be covered. The following statement shall be included in all marketing materials in boldface type:

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

The notice shall be followed by a telephone number to contact the plan.

(2) A description of all necessary prior authorizations or other requirements for nonemergency health care services.

(3) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, copayments, deductibles and other charges, annual limits on an enrollee's financial responsibility and caps on payments for health care services provided under the plan.

(4) An explanation of an enrollee's financial responsibility for payment when a health care service is provided by a
nonparticipating health care provider, when a health care service is provided by any health care provider without required authorization or when the care rendered is not covered by the plan.

(5) A description of how the managed care plan addresses the needs of non-English-speaking enrollees.

(6) A notice of mailing addresses and telephone numbers necessary to enable an enrollee to obtain approval or authorization of a health care service or other information regarding the plan.

(7) A summary of the plan's utilization review policies and procedures.

(8) A summary of all complaint and grievance procedures used to resolve disputes between the managed care plan and an enrollee or a health care provider, including:
   (i) The procedure to file a complaint or grievance as set forth in this article, including a toll-free telephone number to obtain information regarding the filing and status of a complaint or grievance.
   (ii) The right to appeal a decision relating to a complaint or grievance.
   (iii) The enrollee's right to designate a representative to participate in the complaint or grievance process as set forth in this article.
   (iv) A notice that all disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice and that all notices of decisions will include information regarding the basis for the determination.

(9) A description of the procedure for providing emergency services twenty-four (24) hours a day. The description shall include:
   (i) A definition of emergency services as set forth in this article.
   (ii) Notice that emergency services are not subject to prior approval.
   (iii) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the managed care plan's service area.

(10) A description of the procedures for enrollees to select a participating health care provider, including how to determine whether a participating health care provider is accepting new enrollees.

(11) A description of the procedures for changing primary care providers and specialists.

(12) A description of the procedures by which an enrollee may obtain a referral to a health care provider outside the provider network when that provider network does not include a health care provider with appropriate training and experience to meet the health care service needs of an enrollee.

(13) A description of the procedures that an enrollee with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:
   (i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or
   (ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

(14) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually.
(15) A list of the information available to enrollees or prospective enrollees, upon written request, under subsection (b).

(b) Each managed care plan shall, upon written request of an enrollee or prospective enrollee, provide the following written information:

(1) A list of the names, business addresses and official positions of the membership of the board of directors or officers of the managed care plan.

(2) The procedures adopted to protect the confidentiality of medical records and other enrollee information.

(3) A description of the credentialing process for health care providers.

(4) A list of the participating health care providers affiliated with participating hospitals.

(5) Whether a specifically identified drug is included or excluded from coverage.

(6) A description of the process by which a health care provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

(7) A description of the procedures followed by the managed care plan to make decisions about the experimental nature of individual drugs, medical devices or treatments.

(8) A summary of the methodologies used by the managed care plan to reimburse for health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a managed care plan and a health care provider.

(9) A description of the procedures used in the managed care plan's quality assurance program.

(10) Other information as may be required by the department or the Insurance Department.

(2136 added June 17, 1998, P.L.464, No.68)

(g) Complaints.

(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2141. Internal Complaint Process.--(a) A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan.

(b) The complaint process shall consist of an initial review to include all of the following:

(1) A review by an initial review committee consisting of one or more employes of the managed care plan.

(2) The allowance of a written or oral complaint.

(3) The allowance of written data or other information.

(4) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.

(5) A written notification to the enrollee regarding the decision of the initial review committee within five (5) business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.
(c) The complaint process shall include a second level review that includes all of the following:

(1) A review of the decision of the initial review committee by a second level review committee consisting of three or more individuals who did not participate in the initial review. At least one third of the second level review committee shall not be employed by the managed care plan.

(2) A written notification to the enrollee of the right to appear before the second level review committee.

(3) A requirement that the second level review be completed within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis for the decision and the procedure for appealing the decision to the department or the Insurance Department.

(2141 added June 17, 1998, P.L.464, No.68)

Section 2142. Appeal of Complaint.--(a) An enrollee shall have fifteen (15) days from receipt of the notice of the decision from the second level review committee to appeal the decision to the department or the Insurance Department, as appropriate.

(b) All records from the initial review and second level review shall be transmitted to the appropriate department in the manner prescribed. The enrollee, the health care provider or the managed care plan may submit additional materials related to the complaint.

(c) The enrollee may be represented by an attorney or other individual before the appropriate department.

(d) The appropriate department shall determine whether a violation of this article has occurred and may impose any penalties authorized by this article.

(2142 added June 17, 1998, P.L.464, No.68)

Section 2143. Complaint Resolution.--Nothing in this subdivision shall prevent the department or the Insurance Department from communicating with the enrollee, the health care provider or the managed care plan as appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

(2143 added June 17, 1998, P.L.464, No.68)

(h) Utilization Review.

(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2151. Certification.--(a) A utilization review entity may not review health care services delivered or proposed to be delivered in this Commonwealth unless the entity is certified by the department to perform utilization review. A utilization review entity operating in this Commonwealth on or before the effective date of this article shall have one year from the effective date of this article to apply for certification.

(b) The department shall grant certification to a utilization review entity that meets the requirements of this section. Certification shall be renewed every three years unless otherwise subject to additional review, suspension or revocation by the department.

(c) The department may adopt a nationally recognized accrediting body's standards to certify utilization review entities to the extent the standards meet or exceed the standards set forth in this article.
(d) The department may prescribe application and renewal fees for certification. The fees shall reflect the administrative costs of certification and shall be deposited in the General Fund.

(e) A licensed insurer or a managed care plan with a certificate of authority shall comply with the standards and procedures of this subdivision but shall not be required to obtain separate certification as a utilization review entity.

(2151 added June 17, 1998, P.L.464, No.68)

Section 2152. Operational Standards.--(a) A utilization review entity shall do all of the following:

(1) Respond to inquiries relating to utilization review determinations by:
   (i) providing toll-free telephone access at least forty (40) hours per week during normal business hours;
   (ii) maintaining a telephone answering service or recording system during nonbusiness hours; and
   (iii) responding to each telephone call received by the answering service or recording system regarding a utilization review determination within one (1) business day of the receipt of the call.

(2) Protect the confidentiality of enrollee medical records as set forth in section 2131.

(3) Ensure that a health care provider is able to verify that an individual requesting information on behalf of the managed care plan is a legitimate representative of the plan.

(4) Conduct utilization reviews based on the medical necessity and appropriateness of the health care service being reviewed and provide notification within the following time frames:
   (i) A prospective utilization review decision shall be communicated within two (2) business days of the receipt of all supporting information reasonably necessary to complete the review.
   (ii) A concurrent utilization review decision shall be communicated within one (1) business day of the receipt of all supporting information reasonably necessary to complete the review.
   (iii) A retrospective utilization review decision shall be communicated within thirty (30) days of the receipt of all supporting information reasonably necessary to complete the review.

(5) Ensure that personnel conducting a utilization review have current licenses in good standing or other required credentials, without restrictions, from the appropriate agency.

(6) Provide all decisions in writing to include the basis and clinical rationale for the decision.

(7) Notify the health care provider of additional facts or documents required to complete the utilization review within forty-eight (48) hours of receipt of the request for review.

(8) Maintain a written record of utilization review decisions adverse to enrollees for not less than three (3) years, including a detailed justification and all required notifications to the health care provider and the enrollee.

(b) Compensation to any person or entity performing utilization review may not contain incentives, direct or indirect, for the person or entity to approve or deny payment for the delivery of any health care service.

(c) Utilization review that results in a denial of payment for a health care service shall be made by a licensed physician, except as provided in subsection (d).
(d) A licensed psychologist may perform a utilization review for behavioral health care services within the psychologist's scope of practice if the psychologist's clinical experience provides sufficient experience to review that specific behavioral health care service. The use of a licensed psychologist to perform a utilization review of a behavioral health care service shall be approved by the department as part of the certification process under section 2151. A licensed psychologist shall not review the denial of payment for a health care service involving inpatient care or a prescription drug.

(2152 added June 17, 1998, P.L.464, No.68)

(i) Grievances.

(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2161. Internal Grievance Process.--(a) A managed care plan shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(b) The internal grievance process shall consist of an initial review that includes all of the following:

(1) A review by one or more persons selected by the managed care plan who did not previously participate in the decision to deny payment for the health care service.

(2) The completion of the review within thirty (30) days of receipt of the grievance.

(3) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

(c) The grievance process shall include a second level review that includes all of the following:

(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.

(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.

(3) The completion of the second level review within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.

(d) Any initial review or second level review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.

(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee
and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

(2161 added June 17, 1998, P.L.464, No.68)

Section 2162. External Grievance Process.--(a) A managed care plan shall establish and maintain an external grievance process by which an enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with the managed care plan.

(b) To conduct external grievances filed under this section:
(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the managed care plan within two (2) business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the managed care plan shall designate and notify a certified utilization review entity to conduct the external grievance.
(2) The managed care plan shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.

(c) The external grievance process shall meet all of the following requirements:
(1) Any external grievance shall be filed with the managed care plan within fifteen (15) days of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the managed care plan shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.
(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.
(3) The utilization review entity conducting the external grievance shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.
(4) An external grievance decision shall be made by:
   (i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or
   (ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.
(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the managed care plan, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the plan. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in favor of the decision of the utilization review entity conducting the external grievance.

(6) The managed care plan shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(7) All fees and costs related to an external grievance shall be paid by the nonprevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or managed care plan shall each place in escrow an amount equal to one-half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the managed care plan. For purposes of this paragraph, fees and costs shall not include attorney fees.

(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.

(e) A fee may be imposed by a managed care plan for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

(f) Written contracts between managed care plans and health care providers may provide an alternative dispute resolution system to the external grievance process set forth in this article if the department approves the contract. The alternative dispute resolution system shall be impartial, include specific time limitations to initiate appeals, receive written information, conduct hearings and render decisions and otherwise satisfy the requirements of this section. A written decision pursuant to an alternative dispute resolution system shall be final and binding on all parties. An alternative dispute resolution system shall not be utilized for any external grievance filed by an enrollee.

(2162 added June 17, 1998, P.L.464, No.68)

Section 2163. Records.—Records regarding grievances filed under this subdivision that result in decisions adverse to enrollees shall be maintained by the plan for not less than three (3) years. These records shall be provided to the department, if requested, in accordance with section 2131(c)(2)(ii).

(2163 added June 17, 1998, P.L.464, No.68)

(j) Prompt Payment.

(Subdiv. added June 17, 1998, P.L.464, No. 68)
Section 2166. Prompt Payment of Claims.--(a) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

(2166 added June 17, 1998, P.L.464, No.68)

(k) Health Care Provider and Managed Care Plan Protection.

(2171 added June 17, 1998, P.L.464, No.68)

Section 2171. Health Care Provider and Managed Care Plan Protection.--(a) A managed care plan shall not exclude, discriminate against or penalize any health care provider for its refusal to allow, perform, participate in or refer for health care services when the refusal of the health care provider is based on moral or religious grounds and that provider makes adequate information available to enrollees or, if applicable, prospective enrollees.

(b) No public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan or operating, expanding or improving an existing plan because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other plans when the refusal is based on moral or religious grounds.

(2171 added June 17, 1998, P.L.464, No.68)

(l) Enforcement.

(2181 added June 17, 1998, P.L.464, No.68)

Section 2181. Departmental Powers and Duties.--(a) The department shall require that records and documents submitted to a managed care plan or utilization review entity as part of any complaint or grievance be made available to the department, upon request, for purposes of enforcement or compliance with this article.

(b) The department shall compile data received from a managed care plan on an annual basis regarding the number, type and disposition of complaints and grievances filed with a managed care plan under this article.

(c) The department shall issue guidelines identifying those provisions of this article that exceed or are not included in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance. These guidelines shall be published in the Pennsylvania Bulletin and updated as necessary. Copies of the guidelines shall be made available to managed care plans, health care providers and enrollees upon request.

(d) The department and the Insurance Department shall ensure compliance with this article. The appropriate department shall investigate potential violations of the article based upon information received from enrollees, health care providers and other sources in order to ensure compliance with this article.
(e) The department and the Insurance Department shall promulgate such regulations as may be necessary to carry out the provisions of this article.

(f) The department in cooperation with the Insurance Department shall submit an annual report to the General Assembly regarding the implementation, operation and enforcement of this article.

(2181 added June 17, 1998, P.L.464, No.68)

Section 2182. Penalties and Sanctions.--(a) The department or the Insurance Department, as appropriate, may impose a civil penalty of up to five thousand ($5,000) dollars for a violation of this article.

(b) A managed care plan shall be subject to the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."

(c) The department or the Insurance Department may maintain an action in the name of the Commonwealth for an injunction to prohibit any activity which violates the provisions of this article.

(d) The department may issue an order temporarily prohibiting a managed care plan which violates this article from enrolling new members.

(e) The department may require a managed care plan to develop and adhere to a plan of correction approved by the department. The department shall monitor compliance with the plan of correction. The plan of correction shall be available to enrollees of the managed care plan upon request.

(f) In no event shall the department and the Insurance Department impose a penalty for the same violation.

(2182 added June 17, 1998, P.L.464, No.68)

Section 2183. Administrative Review.--The provisions of this article shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).

(2183 added June 17, 1998, P.L.464, No.68)

(m) Miscellaneous.

(Subdiv. added June 17, 1998, P.L.464, No.68)

Section 2191. Compliance with National Accrediting Standards.--Notwithstanding any other provision of this article to the contrary, the department shall give consideration to a managed care plan's demonstrated compliance with the standards and requirements set forth in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance or other department-approved quality review organizations in determining compliance with the same or similar provisions of this article. The managed care plan, however, shall remain subject to and shall comply with any other provisions of this article that exceed or are not included in the standards of the National Committee for Quality Assurance or other department-approved quality review organizations.

(2191 added June 17, 1998, P.L.464, No.68)

Section 2192. Exceptions.--This article shall not apply to any of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act."

(2) The act of July 1, 1937 (P.L.2532, No.470), known as the "Workers' Compensation Security Fund Act."

(3) Peer review, utilization review or mental or physical examinations performed under 75 Pa.C.S. Ch. 17 (relating to financial responsibility).
The fee-for-service programs operated by the Department of Public Welfare under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

(2192 added June 17, 1998, P.L.464, No.68)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 2193. Preemption.--Nothing in this article shall regulate or authorize regulation which would be ineffective by reason of the State law preemption provisions of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

(2193 added June 17, 1998, P.L.464, No.68)

Section 2194. Managed Care Plans Participating in the Medical Assistance Program.--(a) The General Assembly finds that:

(1) Accessibility to health care services received by participants in the Commonwealth's medical assistance program must be maintained throughout this Commonwealth.

(2) The quality and continuity of these services must be assured in a manner that responsibly and effectively controls medical assistance costs.

(3) Managed care plans contracting with the Department of Public Welfare for purposes of participation in the medical assistance program have developed across this Commonwealth and provide vital health care services, including pharmaceuticals, to the medical assistance population of this Commonwealth.

(4) A review of the delivery of services provided by these managed care plans is necessary to enable the Department of Public Welfare, in consultation with the department, to formulate a strategy that properly utilizes cost control mechanisms that produce available savings to the Commonwealth if an effective and responsive health care network is to be maintained across this Commonwealth, especially due to continuing changes at the Federal level.

(b) The Legislative Budget and Finance Committee shall conduct a review of and issue a report on the delivery and quality of health care services provided through the current fee-for-service program as well as by managed care plans participating in the Commonwealth's medical assistance program. The report shall include the following for each service delivery system:

(1) Information regarding the number of medical assistance participants per service per county, separated by those served and those denied.

(2) The total cost or savings accrued to the Commonwealth itemized by county per service provided, including pharmaceuticals.

(3) Recommendations for revisions in practices used by the Department of Public Welfare to contract and provide for all health care services available through the medical assistance program.

(4) Any other recommendations that will promote medical assistance program savings.

(c) The Department of Public Welfare and all other affected State agencies shall cooperate fully with the Legislative Budget and Finance Committee in providing any and all information necessary to conduct its review and prepare its report.

(d) The Legislative Budget and Finance Committee shall report its findings and recommendations no later than March 1, 2007, to the Governor, the Secretary of Public Welfare, the
Insurance Commissioner, the chairman and minority chairman of the Public Health and Welfare Committee of the Senate, the chairman and minority chairman of the Health and Human Services Committee of the House of Representatives, the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

(e) For purposes of this section, "medical assistance" shall be defined as the State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

(2194 added Nov. 2, 2006, P.L.1314, No.136)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

ARTICLE XXIII.
CHILDREN'S HEALTH CARE.
(Art. repealed Dec. 20, 2015, P.L.461, No.84)

(a) General Provisions.
(Subdiv. repealed Dec. 20, 2015, P.L.461, No.84)

Section 2301. Short Title.--(2301 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2302. Legislative Findings and Intent.--(2302 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2303. Definitions.--(2303 repealed Dec. 20, 2015, P.L.461, No.84)

(b) Primary Health Care Programs.
(Subdiv. repealed Dec. 20, 2015, P.L.461, No.84)

Section 2311. Children's Health Care.--(2311 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2312. Outreach.--(2312 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2313. Payor of Last Resort; Insurance Coverage.--(2313 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2314. State Plan.--(2314 repealed Dec. 20, 2015, P.L.461, No.84)

(c) through (f)
(Reserved)
(Subdivs. repealed Dec. 20, 2015, P.L.461, No.84)

(g) Miscellaneous Provisions.
(Subdiv. repealed Dec. 20, 2015, P.L.461, No.84)

Section 2361. Limitation on Expenditure of Funds.--(2361 repealed Dec. 20, 2015, P.L.461, No.84)
Section 2362. Expiration.--(2362 repealed Dec. 20, 2015, P.L.461, No.84)
ARTICLE XXIII-A.
COMPREHENSIVE HEALTH CARE
FOR UNINSURED CHILDREN.
(Art. added Dec. 20, 2015, P.L.461, No.84)

Compiler's Note: See section 4 of Act 84 of 2015 in the appendix of this act for special provisions relating to continuation of prior law.

Section 2301-A. Definitions.
The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:
"Child." An individual under 19 years of age.
"Contractor." An insurer awarded a contract under section 2304-A to provide health care services under this article. The term includes an entity and an entity's subsidiary which is established under this act, 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.
"Council." The Children's Health Advisory Council established in section 2303-A.
"Department." The Department of Human Services of the Commonwealth.
"EPSDT." Early and periodic screening, diagnosis and treatment.
"Express lane eligibility." A process which permits the use of findings for eligibility factors, including income and household size from an express lane partner administering a government program.
"Express lane partner." An agency determining eligibility for assistance for any of the following programs:
(1) Supplemental Nutrition Assistance Program (SNAP).
(2) Child care provided under the Child Care and Development Block Grant Act of 1990 (Public Law 101-508, 42 U.S.C. § 9858 et seq.).
"Fund." The Children's Health Fund.
"Group." A group for which a health insurance policy is written in this Commonwealth.
"Health service corporation." A professional health service corporation as defined in section 2302-A.
"Healthy Beginnings Program." Medical assistance coverage for services to children as required under Title XIX for the following:
(1) Children from birth to one year of age whose family income is not greater than 185% of the Federal poverty level.
(2) Children one through five years of age whose family income is not greater than 133% of the Federal poverty level.
(3) Children 6 through 18 years of age whose family income is not greater than 133% of the Federal poverty level.
"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill individuals. The term includes facilities for the diagnosis and treatment of disorders within
the scope of specific medical specialties. The term does not include facilities caring exclusively for the mentally ill.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Insurer." A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under any of the following:

1. This act.
3. The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.
4. 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Medicaid." The Federal medical assistance program established under Title XIX.

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Mid-level health professional." A physician assistant, certified registered nurse practitioner, nurse practitioner or certified nurse midwife.

"Parent." A natural parent, stepparent, adoptive parent, guardian or custodian of a child.

"Premium assistance program." A component of a separate child health program, approved under the State plan, under which the Commonwealth pays part or all of the premium for an enrollee or enrollee's group health insurance coverage or coverage under a group health plan.

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Secretary." The Secretary of Human Services of the Commonwealth.

"Terminate." The term includes cancellation, nonrenewal and rescission.

"Title XIX." Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.).

"Title XXI." Title XXI of the Social Security Act.

(2301-A added Dec. 20, 2015, P.L.461, No.84)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 2302-A. Children's health care.

(a) Federal funds.--Notwithstanding any other provision of law, the department shall ensure the receipt of Federal financial participation under Title XXI for services provided under this chapter.

(b) General care.--To ensure that inpatient hospital care is provided to eligible children, each primary care provider furnishing primary care services shall make necessary arrangements for admission to the hospital and for necessary specialty care.
(c) Enrollment.--Subject to the provisions of section 2304-A, an insurer receiving funds from the department to provide coverage of health care services under this section shall enroll, to the extent that funds are available, any child who meets all of the following:

1. Is a resident of this Commonwealth.

2. Is not:
   i. Covered by a health insurance plan.
   ii. Covered by a self-insurance plan.
   iii. Covered by a self-funded plan.
   iv. Provided access to health care coverage by court order.
   v. Eligible for or covered by a medical assistance program administered by the department, including the Healthy Beginnings Program.

3. Is qualified based on income under subsections (d) and (e).

4. Meets the citizenship requirements of Title XXI.

(d) Income levels.--The provision of health care insurance for eligible children shall be in accordance with the following:

1. Free to a child whose family income is no greater than 200% of the Federal poverty level.

2. May be subsidized by the fund at a rate not to exceed 75% of the per member per month premium cost for a child whose family income is greater than 200% of the Federal poverty level but not greater than 250% of the Federal poverty level.

3. May be subsidized by the fund at a rate not to exceed 65% of the per member per month premium cost for a child whose family income is greater than 250% of the Federal poverty level but not greater than 275% of the Federal poverty level.

4. May be subsidized by the fund at a rate not to exceed 60% of the per member per month premium for a child whose family income is greater than 275% of the Federal poverty level but not greater than 300% of the Federal poverty level.

5. Notwithstanding paragraphs (1), (2), (3) and (4), for purposes of determining cost-sharing obligations of a family with income levels specified under paragraphs (2), (3) and (4), the per member per month premium shall exclude the cost related to an assessment imposed on a contractor relating to managed care organization assessments under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(e) Income exceeding limits.--The following apply:

1. For an eligible child whose family income is greater than the maximum level established under section 2304-A(h), the family may purchase the minimum coverage package under 2304-A(e)(9) for that child at the per member per month premium cost. The cost shall be derived separately from the other eligibility categories in the program. The family may purchase the minimum coverage package if the family demonstrates on an annual basis and in a manner determined by the department that the family is unable to afford individual or group coverage because of one of the following reasons:
   i. The coverage would exceed 10% of the family income.
   ii. The total cost of coverage for the child is 150% of the greater of:
(A) the premium cost established under this subsection for that service area; or
(B) the premium cost established under the program for that service area.

(2) For purposes of this subsection, the per member per month premium cost shall exclude the cost related to the managed care organization assessment imposed on a contractor under the Public Welfare Code.

(3) For purposes of this subsection, the term "coverage" may not include coverage offered through accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

(f) Powers and duties.--

(1) For enrollees under subsection (d)(2), (3) or (4) or (e), the following apply:

(i) The department may impose copayments for the following services, except as otherwise prohibited by law:

(A) Outpatient visits.
(B) Emergency room visits.
(C) Prescription medications.
(D) Any other service defined by the department.

(ii) The department may establish and adjust the levels of these copayments in order to impose reasonable cost sharing and to encourage appropriate utilization of these services. The premiums and copayments for enrollees under subsection (d)(2), (3) or (4) may not amount to more than the percent of total household income which is in accordance with the requirements of the Centers for Medicare and Medicaid Services.

(2) The department shall:

(i) Administer the children's health insurance program in accordance with this chapter.

(ii) Review all bids and approve and execute all contracts for the purpose of expanding access to health care services for eligible children as provided for in this article.

(iii) Conduct monitoring and oversight of contracts.

(iv) Issue an annual report to the Governor, the General Assembly and the public for each calendar year no later than March 1 of each year providing for the following:

(A) The primary health services funded for the year.
(B) The outreach and enrollment efforts and the number of children by county and by percent of the Federal poverty level who are receiving health care services.
(C) The projected number of eligible children by county and by percent of the Federal poverty level.
(D) The number of eligible children on waiting lists for enrollment in the children's health insurance program established under this article by county and by percent of the Federal poverty level.
(E) The details of the department's efforts on the implementation of express lane eligibility.
(v) In consultation with appropriate Commonwealth agencies, coordinate the development and supervision of the outreach plan required under section 2305-A.

(vi) In consultation with appropriate Commonwealth agencies, monitor, review and evaluate the adequacy, accessibility and availability of services delivered to children who are enrolled in the children's health insurance program established under this article.

(vii) Enter into arrangements, including memoranda of understanding, with the Insurance Department and other appropriate Federal or State agencies, as may be necessary to carry out the department's duties under this article.

(3) The department may promulgate regulations necessary for the implementation and administration of this article.

(2302-A added Dec. 20, 2015, P.L.461, No.84)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 2303-A. Children's Health Advisory Council.
The Children's Health Advisory Council is established within the department as an advisory council. The following apply:

(1) The council shall consist of 16 voting members. Members provided for in subparagraphs (iv), (v), (vi), (vii), (viii), (xiii), (xiv), (xv) and (xvi) shall be appointed by the secretary. The council shall be geographically balanced on a Statewide basis and shall include:

(i) The Secretary of Health ex officio or a designee.

(ii) The Insurance Commissioner ex officio or a designee.

(iii) The secretary ex officio or a designee.

(iv) A representative with experience in children's health from a school of public health located in this Commonwealth.

(v) A physician with experience in children's health appointed from a list of three qualified persons recommended by the Pennsylvania Medical Society.

(vi) A representative of a children's hospital or a hospital with a pediatric outpatient clinic appointed from a list of three persons submitted by the Hospital Association of Pennsylvania.

(vii) A parent of a child who receives primary health care coverage from the fund.

(viii) A mid-level professional appointed from lists of names recommended by Statewide associations representing mid-level health professionals.

(ix) A senator appointed by the President pro tempore of the Senate.

(x) A senator appointed by the Minority Leader of the Senate.

(xi) A representative appointed by the Speaker of the House of Representatives.

(xii) A representative appointed by the Minority Leader of the House of Representatives.

(xiii) A representative from a private nonprofit foundation.
A representative of a nonprofit business who is a contractor or provider of primary health insurance under this article.

A representative of a for-profit business who is a contractor or provider of primary health insurance under this article.

(2) If a specified organization ceases to exist or fails to make a recommendation within 90 days of a request, the council shall specify a new equivalent organization to fulfill the responsibilities of this section.

(3) The secretary shall serve as chairperson of the council. The members of the council shall annually elect, by a majority vote of the members, a vice chairperson from among the members of the council.

(4) The presence of nine members shall constitute a quorum for the transacting of any business. An act by a majority of the members present at a meeting at which there is a quorum shall be deemed to be that of the council.

(5) All meetings of the council shall be conducted in accordance with 65 Pa.C.S. Ch. 7 (relating to open meetings), except as provided in this section. Meetings must be in accordance with the following:

   (i) The council shall meet at least twice per year and may provide for special meetings as the council deems necessary.

   (ii) Meeting dates shall be set by a majority vote of members of the council or by call of the chairperson upon seven days' notice to all members.

   (iii) The council shall publish notice of the council's meetings in the Pennsylvania Bulletin. The notice must specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public.

   (iv) All action taken by the council shall be taken in open public session and may not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.

(6) The members of the council may not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of the members' duties.

(7) Terms of council members shall be as follows:

   (i) The appointed members shall serve for a term of three years and shall continue to serve until a successor is appointed.

   (ii) An appointed member may not be eligible to serve more than two full consecutive terms of three years. Vacancies shall be filled in the same manner as the original appointment within 60 days of the vacancy.

   (iii) An appointed member may be removed by the appointing authority for just cause and by a vote of at least seven members of the council.

(8) The council shall review outreach activities and may make recommendations to the department.

(9) The council shall review and evaluate the accessibility and availability of services delivered to children enrolled in the program.

(2303-A added Dec. 20, 2015, P.L.461, No.84)

Section 2304-A. Contracts and coverage packages.
(a) Paid from fund.--In addition to any other requirements provided by law, the fund shall be operated in accordance with the following:

(1) The fund must be dedicated exclusively for distribution by the department through contracts in order to provide free and subsidized health care services under this article, based on an actuarially sound and adequate review, and to develop and implement outreach activities required under section 2305-A.

(2) The fund, along with Federal, State and other funds available for the program, must be used for health care coverage for children as specified in this article. The department shall ensure that the program is implemented Statewide.

(3) The department must award contracts paid from the fund in accordance with the following:

(i) All contracts awarded under this subsection must be awarded through a competitive procurement process. The department and the Insurance Department must use their best efforts to ensure that eligible children across this Commonwealth have access to health care services to be provided under this article.

(ii) No more than 10% of the amount of the contract may be used for administrative expenses of the contractor. If a contractor presents documented evidence that administrative expenses for purposes of expanded outreach and systems and operational changes are in excess of 10% of the amount of the contract, the department shall make an additional allotment of funds, not to exceed 2% of the amount of the contract, to the contractor to the extent that the department finds the expenses reasonable and necessary.

(iii) At least 84% of the amount of the contract shall be used to provide health care services for children eligible for care under this article.

(iv) In determining the amount of the contract which may be used for the purposes specified in subparagraphs (ii) and (iii), any Federal and State taxes that would be deducted from premium revenue in determining an issuer's medical loss ratio under 45 CFR 158.221 (relating to formula for calculating an issuer's medical loss ratio), including a managed care organization assessment imposed on a contractor under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, shall be excluded.

(b) Solicitation of contracts.--The department must solicit bids and award contracts through a competitive procurement process in accordance with the following:

(1) To the fullest extent practicable, contracts shall be awarded to insurers that contract with providers to provide primary care services for enrollees on a cost-effective basis. The department shall require contractors to use appropriate cost-management methods so that basic primary coverage services can be provided to the maximum number of eligible children and, if possible, to pursue and utilize available public and private funds.

(2) To the fullest extent practicable, the department must require that a contractor comply with all procedures relating to coordination of health care services as required by the department or the Insurance Department.

(3) Contracts may be for a term of up to three years, with the option to extend for two one-year periods.
(c) Bidding.--Upon receipt of a solicitation from the department, each health service corporation and hospital plan corporation or their entities doing business in this Commonwealth shall submit a bid or proposal to the department to carry out the purposes of this article in the area serviced by the corporation.

(d) Bidding by other insurers.--All other insurers may submit a bid or proposal to the department to carry out the purposes of this article.

(e) Duties of contractor.--A contractor with whom the department enters into a contract shall do the following:

1. Ensure to the maximum extent possible that eligible children have access to primary health care physicians and nurse practitioners within the contractor's service area.

2. Contract with qualified, cost-effective providers, which may include primary health care physicians, nurse practitioners, clinics and HMOs, to provide primary and preventive health care for enrollees on a basis best calculated to manage the costs of the services, including, but not limited to, using managed health care techniques and other appropriate medical cost-management methods.

3. Ensure that the family of a child who may be eligible for medical assistance receives assistance in applying for medical assistance.

4. Maintain waiting lists of children financially eligible for coverage who have applied for coverage but who were not enrolled due to lack of funds.

5. Notify families of children who are paying a premium of any changes in such premium or copayment requirements.

6. Collect premiums or copayments from the family of a child receiving coverage as may be required.

7. Cancel coverage for nonpayment of premium, in accordance with all applicable insurance laws.

8. Strongly encourage all providers who provide primary care to eligible children to participate in medical assistance as qualified EPSDT providers and to continue to provide care to children who become ineligible for coverage under the provisions of this article but who qualify for medical assistance.

9. Subject to any necessary Federal approval, provide the following minimum coverage package, which may not conflict with Federal law, regulation or guidance, for eligible children:

   (i) Preventive care. This subparagraph shall include:

      (A) Well-child care visits in accordance with the schedule established by the American Academy of Pediatrics and the services related to the visits, including immunizations, health education, tuberculosis testing and developmental screening in accordance with the routine schedule of well-child care visits.

      (B) A comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child abuse.

   (ii) Diagnosis and treatment of illness or injury, including all medically necessary services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such as laboratory tests, wound dressing and casting to immobilize fractures.
(iii) Injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital or freestanding ambulatory service center, including anesthesia provided in conjunction with such service or during emergency medical service.

(iv) Emergency accident and emergency medical care.

(v) Prescription drugs.

(vi) Emergency, preventive and routine dental care. This subparagraph does not include orthodontia or cosmetic surgery.

(vii) Emergency, preventive and routine vision care, including the cost of corrective lenses and frames, not to exceed two prescriptions per year.

(viii) Emergency, preventive and routine hearing care.

(ix) Inpatient hospitalization.

(10) The department may implement a premium assistance program permitted under Federal regulations and as permitted through Federal waiver or State plan amendment made pursuant to this article. Notwithstanding any other law to the contrary, if it is more cost effective to purchase health care from a parent's employer-based program and the employer-based program meets the minimum coverage requirements, employer-based coverage may be purchased in place of enrollment in the children's health insurance program established under this article. An insurer must honor a request for enrollment and purchase of employee group health insurance requested on behalf of an individual applying for coverage under this chapter if the individual:

(i) is a resident of this Commonwealth;

(ii) is qualified based on income under section 2302-A; and

(iii) meets the citizenship requirements of section 2302-A(c)(1)(iv).

(11) The department shall have the authority to review, audit and approve annual administrative expenses incurred by contractors under this section.

(12) Except for children covered under paragraph (10), each contractor shall provide a coverage identification card to each eligible child covered under contracts executed under this article. The card must not specifically identify the holder as low income.

(f) Waiver of minimum.--The department may grant a waiver of the minimum coverage package of subsection (e)(9) upon demonstration by the applicant that the applicant is providing health care services for eligible children that meet the purposes and intent of this article.

(g) Review.--

(1) The department, in consultation with appropriate Commonwealth agencies, shall review enrollment patterns for both the free coverage program and the subsidized coverage program. The department shall consider the relationship, if any, among enrollment, enrollment fees, income levels and family composition.

(2) Based on the results of this study and the availability of funds, the department may adjust the maximum income ceiling for free coverage and the maximum income ceiling for subsidized coverage by regulation. The maximum income ceiling for free coverage may not be raised above 200% of the Federal poverty level.
Limit.--Notwithstanding subsection (g) and subject to section 2307-A, the maximum income ceiling for subsidized coverage under section 2302-A(d)(2), (3) or (4) may not be raised above 300% of the Federal poverty level.

(2304-A added Dec. 20, 2015, P.L.461, No.84)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 2305-A. Outreach.

(a) Plan.--The department, in consultation with appropriate Commonwealth agencies, must coordinate the development of an outreach plan to inform potential contractors, providers and enrollees regarding eligibility and available coverage. The plan must include provisions for all of the following:

   (1) Reaching special populations, including nonwhite and non-English-speaking children and children with disabilities.

   (2) Reaching different geographic areas, including rural and inner-city areas.

   (3) Ensuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

   (4) Comparing children enrolled in child care provided under the Child Care and Development Block Grant Act of 1990 (Public law 101-508, 42 U.S.C. § 9858 et seq.) or enrolled in the Supplemental Nutrition Assistance Program in the determination of a child's eligibility for coverage under this article and implement express lane eligibility as appropriate. The department is authorized to expand the agencies identified as express lane partners by the issuance of a statement of policy.

   (5) Notice of the existence of and eligibility for the program shall be prepared by the department and provided to the Department of Education for dissemination to nonpublic and public schools electronically, on an annual basis, not later than August 15.

(b) Review.--The council shall review the outreach activities and recommend changes as the council deems to be in the best interests of the children to be served.

(2305-A added Dec. 20, 2015, P.L.461, No.84)

Section 2306-A. Payor of last resort and insurance coverage.

The contractor may not pay a claim on behalf of an enrolled child unless all other Federal, State, local or private resources available to the child or the child's family are utilized first. The department, in cooperation with the Insurance Department, shall determine if insurance coverage is available to the child through a custodial or noncustodial parent on an employment-related or other group basis. If insurance coverage is available, the child's eligibility under section 2302-A and the most cost-effective means of providing coverage for that child must be reevaluated.

(2306-A added Dec. 20, 2015, P.L.461, No.84)

Section 2307-A. State plan.

The department may amend the State plan as necessary to carry out the provisions of this article.

(2307-A added Dec. 20, 2015, P.L.461, No.84)

Section 2308-A. Limitation on expenditure of funds.

The total amount of annual contract awards authorized under this article may not exceed the amount of cigarette tax receipts annually deposited into the fund under section 1296 of the act...
of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, and any other Federal or State funds received through the fund. The provision of children's health care through the fund may not constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

(2308-A added Dec. 20, 2015, P.L.461, No.84)

Section 2309-A. Expiration.
(a) General rule.--Subject to subsection (a.1), this article shall expire on the earlier of:
   (1) December 31, 2019; or
   (2) ninety days after the date on which Federal funding for the program ceases to be available.
(a.1) Exception.--If Federal law authorizes funding for the program for a period that extends beyond December 31, 2019, this article shall expire under subsection (a)(2).
(b) Notice.--If this article expires under subsection (a)(2), as determined by the department, the department shall transmit notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.


ARTICLE XXIV
FRATERNAL BENEFIT SOCIETIES
(Art. added July 10, 2002, P.L.749, No.110)

SUBARTICLE A
GENERAL PROVISIONS
(Subart. added July 10, 2002, P.L.749, No.110)

Section 2401. Scope.
This article deals with fraternal benefit societies.
(2401 added July 10, 2002, P.L.749, No.110)

Section 2402. Definitions.
The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:
"Benefit contract." The agreement for provision of benefits authorized by section 2431 as that agreement is described in section 2434(a).
"Benefit member." An adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.
"Certificate." The document issued as written evidence of the benefit contract.
"Commissioner." The Insurance Commissioner of the Commonwealth.
"Department." The Insurance Department of the Commonwealth.
"Impaired." For a society that does not write variable contracts, "impaired" means whenever the society's assets are less than its total liabilities. For a society that does write variable contracts, "impaired" means whenever the society's assets are less than its total liabilities, plus the required surplus for a mutual life insurer to write such contracts.
"Insurance laws." Laws and regulations pertaining to insurance companies.
"Laws." The society's articles of incorporation, constitution and bylaws, however designated.
"Lodge." Subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.
"Premiums." Premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.
"Rules." Rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

"Society." Fraternal benefit society, unless otherwise indicated.

Section 2402. Fraternal benefit societies.
Any incorporated society, order or supreme lodge without capital stock, including one exempted under the provisions of section 2466(a)(2) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with or without ritualistic form of work, having a representative form of government and providing benefits in accordance with this article is declared to be a fraternal benefit society.

Section 2403. Lodge system.
(a) General rule.--A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each quarter in furtherance of the purposes of the society.

(b) Lodges for children.--A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Section 2404. Lodge system.
(a) General rule.--A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each quarter in furtherance of the purposes of the society.

(b) Lodges for children.--A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Section 2405. Representative form of government.
A society has a representative form of government when the following circumstances occur:

(1) It has a supreme governing body constituted in one of the following ways:
   (i) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.
   (ii) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be
considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors.

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly.

(4) Each voting member has one vote; no vote may be cast by proxy.

(2405 added July 10, 2002, P.L.749, No.110)

Section 2406. Purposes, powers and limitations of societies.

(a) Purposes.--A society shall operate for the benefit of members and their beneficiaries by:

(1) providing benefits as specified in section 2431;

and

(2) operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

These purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(b) Powers.--Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members and the management of its affairs. The society shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

(c) Limitations.--No society or subsidiary corporation or affiliated organization through which a society carries out its purposes shall own or operate a funeral home or undertaking establishment.

(2406 added July 10, 2002, P.L.749, No.110)

SUBARTICLE B
MEMBERSHIP
(Subart. added July 10, 2002, P.L.749, No.110)

Section 2411. Qualifications for membership.

(a) General rule.--A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership. If benefits are provided on the lives of children, the minimum age for adult membership shall be 15 years and the maximum age shall be 21 years.

(2) The process for admission to membership for each membership class.

(3) The rights and privileges of each membership class. Only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) Social members.--A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership is personal.--Membership rights in the society are personal to the member and are not assignable.

(2411 added July 10, 2002, P.L.749, No.110)

Section 2412. Office, meetings, publications and grievance procedures.

(a) Office and meetings.--The principal office of any domestic society shall be located in this Commonwealth. The
meetings of the supreme governing body of the society may be held in any state or country on the North American continent or in any other location determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if the meetings were held in this Commonwealth. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b) Publications.--
(1) A society may provide in its laws for an official publication in which any notice, report or statement required by law to be given to members, including notice of election, may be published. Any required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy. This paragraph shall not apply to certificate requirements, reports or notices in connection with the issuance of certificates.

(2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, the synopsis may be published in the society's official publication.

(c) Grievance procedures.--A society may provide in its laws or rules for grievance or complaint procedures for members.

(2412 added July 10, 2002, P.L.749, No.110)

Section 2413. Personal liability.
(a) General rule.--The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Indemnification and reimbursement.--
(1) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by and liabilities imposed upon that person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which that person may be involved by reason of the fact that that person is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which the person served in any capacity at the request of the society.

(2) A person shall not be so indemnified or reimbursed:
   (i) in relation to any matter in an action, suit or proceeding as to which the person shall finally be adjudged to be or have been guilty of a breach of a duty as a director, officer, employee or agent of the society; or
   (ii) in relation to any matter in an action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless, in either case, the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his conduct was unlawful.

(3) The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in
paragraph (2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of no contest as to that person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which that person may be entitled as a matter of law and shall not inure to the benefit of that person's heirs, executors and administrators.

(c) Insurance.--A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation or organization against any liability asserted against that person and incurred in any such capacity or arising out of that person's status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(2413 added July 10, 2002, P.L.749, No.110)

Section 2414. Waiver.

The laws of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

(2414 added July 10, 2002, P.L.749, No.110)

SUBARTICLE C
GOVERNANCE
(Subart. added July 10, 2002, P.L.749, No.110)

Section 2421. Organization.

(a) General rule.--A domestic society organized after February 11, 1993, shall be formed as provided in this section.

(b) Articles of incorporation.--Seven or more citizens of the United States, a majority of whom are citizens of this Commonwealth, who desire to form a fraternal benefit society may make, sign and acknowledge, before some officer competent to take acknowledgment of deeds, articles of incorporation in which shall be stated:

(1) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing.

(2) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this subarticle.

(3) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all the officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.
(c) Filing.--Such articles of incorporation, duly certified
copies of the society's bylaws and rules, copies of all proposed
forms of certificates and applications therefor and circulars
to be issued by the society and a bond conditioned upon the
return to applicants of the advanced payments if the
organization is not completed within one year shall be filed
with the commissioner, who may require such further information
as the commissioner deems necessary. The bond with sureties
approved by the commissioner shall be in an amount, not less
than $300,000 nor more than $1,500,000, as required by the
commissioner. All documents filed shall be in the English
language. If the purposes of the society conform to the
requirements of this subarticle and all provisions of the law
have been complied with, the commissioner shall so certify,
retain and file the articles of incorporation and furnish the
incorporators a preliminary certificate of authority authorizing
the society to solicit members as provided in this section.

(d) Duration of preliminary certificate.--No preliminary
certificate of authority granted under the provisions of this
section shall be valid after one year from its date of issuance
or after a further period, not exceeding one year, as may be
authorized by the commissioner upon cause shown, unless the 500
applicants required under subsection (e) have been secured and
the organization has been completed as provided in this section.
The articles of incorporation and all other proceedings
thereunder shall become null and void in one year from the date
of the preliminary certificate of authority or at the expiration
of the extended period unless the society shall have completed
its organization and received a certificate of authority to do
business as provided in this section.

(e) Solicitation of members.--Upon receipt of a preliminary
certificate of authority from the commissioner, the society may
solicit members for the purpose of completing its organization,
shall collect from each applicant the amount of not less than
one regular monthly premium in accordance with its table of
rates and shall issue to each applicant a receipt for the amount
collected. No society shall incur any liability other than for
the return of the advance premium nor issue any certificate nor
pay or allow or offer or promise to pay or allow any benefit
to any person until the following conditions are met:

(1) Actual bona fide applications for benefits
aggregating at least $500,000 have been secured on not less
than 500 applicants, and any necessary evidence of
insurability has been furnished to and approved by the
society.

(2) At least ten subordinate lodges have been
established into which the 500 applicants have been admitted.

(3) There has been submitted to the commissioner under
oath of the president or secretary or corresponding officer
of the society a list of the applicants, giving the name and
address of each, the date each was admitted, the name and
number of the subordinate lodge of which each applicant is
a member and the amount of benefits to be granted and
premiums for each applicant.

(4) It shall have been shown to the commissioner by
sworn statement of the treasurer or corresponding officer
of the society that at least 500 applicants have each paid
in cash at least one regular monthly premium as provided in
this subsection, which premiums in the aggregate shall amount
to at least $150,000. These advance premiums shall be held
in trust during the period of organization and, if the
society has not qualified for a certificate of authority
within one year as provided in this section, the premiums shall be returned to the applicants.

(5) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and to the effect that the society is authorized to transact business pursuant to the provisions of this subarticle. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

(f) Limitations.--The provisions of subsection (e) shall not apply to:

(1) Any society organized prior to April 6, 1893, under any statute of this Commonwealth which was engaged in doing business in this Commonwealth on that date. After February 12, 1993, any such society may exercise all the rights conferred by this article and all the rights, powers, privileges and exemptions now exercised or possessed by it under its charter or articles of incorporation or articles of association, and neither its existence as a corporation nor its rights to exercise any corporate rights vested in it by virtue of its past incorporation shall be affected by anything contained in this article.

(2) Any fraternal benefit society incorporated under the provisions of the act of April 6, 1893 (P.L.10, No.6), the act of May 20, 1921 (P.L.916, No.324), the act of July 17, 1935 (P.L.1092, No.357), or the act of July 29, 1977 (P.L.105, No.38), relating to fraternal benefit societies. For the purposes of this article, a corporation which is exempt from the requirements of this section by reason of paragraph (1) shall be deemed to be a holder of a certificate of authority issued under this article.

(g) Reincorporation not required.--Any incorporated society authorized to transact business in this Commonwealth on February 12, 1993, shall not be required to reincorporate.

(2421 added July 10, 2002, P.L.749, No.110)

Section 2422. Amendments to laws.

(a) General rule.--A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to the amendment by one of the methods specified in this section. A society having a direct election form of organization as described in section 2405(1)(ii) may amend its constitution or articles of incorporation only by referendum.

(b) Approval of amendment.--No amendment to the laws of any domestic society shall take effect unless approved by the commissioner, who shall approve the amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this...
Commonwealth or with the character, objects and purposes of the society. Unless the commissioner shall disapprove the amendment within 60 days after the filing, the amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and shall be mailed to the secretary or corresponding officer of the society at its principal office. If the commissioner disapproves the amendment, the reasons for the disapproval shall be stated in the written notice.

(c) Copies to members.--Within 90 days from the approval thereof by the commissioner, the amendments or a synopsis thereof shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that the amendments or synopsis thereof have been furnished the addressee.

(d) Filings of foreign societies.--Every foreign or alien society authorized to do business in this Commonwealth shall file with the commissioner a duly certified copy of all amendments of or additions to its laws within 90 days after their enactment.

(e) Certified copies as evidence.--Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption.

(2422 added July 10, 2002, P.L.749, No.110)

Section 2423. Institutions.

A society may create, maintain and operate or may establish organizations to operate not-for-profit institutions to further the purposes permitted by section 2406(a)(2). These institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of the society except as provided in section 2441(b).

(2423 added July 10, 2002, P.L.749, No.110)

Section 2424. Reinsurance.

(a) General rule.--A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this Commonwealth or, if not so authorized, one which is approved by the commissioner, but no society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on the ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed or otherwise becoming effective after February 12, 1993, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Reinsurance by another society.--Notwithstanding the limitation in subsection (a), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 2425.

(2424 added July 10, 2002, P.L.749, No.110)

Section 2425. Consolidations and mergers.
(a) General rule.--A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

1. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger.

2. A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition of the society on a date fixed by the commissioner but not earlier than December 31 next preceding the date of the contract.

3. A certificate of the officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, which vote had been conducted at a regular or special meeting of each body or, if the society's laws permit, by mail.

4. Evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract was furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) Approval by commissioner.--If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to that effect. Upon this approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of that state or territory and a certificate of the approval filed with the commissioner of this Commonwealth or, if the laws of that state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of that state or territory and a certificate of the approval filed with the commissioner of this Commonwealth.

(c) Vesting of rights and liabilities.--When the consolidation or merger becomes effective as provided in this section, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein vested under the laws of this Commonwealth in any of the societies consolidated or merged shall not revert or be in any way impaired by reason of the consolidation or merger but shall vest absolutely in the society resulting from or remaining after the consolidation or merger.

(d) Effect of affidavit.--The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that the notice or document has been furnished the addressees.

(2425 added July 10, 2002, P.L.749, No.110)

Section 2426. Conversion of fraternal benefit society into mutual life insurance company.
Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of this act if the plan of conversion has been approved by the commissioner. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No conversion shall take effect unless and until approved by the commissioner, who may give approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

(2426 added July 10, 2002, P.L.749, No.110)

Section 2427. Domestication.

(a) Filing requirements.--A foreign or alien society authorized to do business in this Commonwealth may become a domestic society by filing with the commissioner in the English language:

(1) Articles of domestication which shall set forth the name of the society, the address, including street and number, of its principal office in this Commonwealth and any other provisions of its current articles of incorporation that the society desires to retain.

(2) A statement that upon domestication the society will be subject to all the laws of this Commonwealth applicable to domestic fraternal benefit societies.

(3) A brief statement of the purpose or purposes for which it is to be domesticated, which shall be a purpose or purposes for which a domestic society may be incorporated under this subarticle.

(4) A certificate of the president and secretary of the society duly verified by their respective oaths that the domestication has been approved in accordance with the constitution and bylaws of the society as required by applicable laws and regulations of the domiciliary jurisdiction.

(b) Approval by commissioner.--If the commissioner finds that the filing by the society is in proper order, that the society complies with the requirements for issuing a certificate of authority to a domestic society, that the society will maintain its principal office in Pennsylvania and that the domestication is in the best interest of the members of the society, the commissioner shall approve the articles of domestication and issue a certificate to that effect.

(c) Effect of domestication.--Upon approval of the articles of domestication by the commissioner, the society shall thereafter become a domestic society and shall be subject to all the laws of this Commonwealth applicable to domestic societies.

(2427 added July 10, 2002, P.L.749, No.110)

SUBARTICLE D
CONTRACTUAL BENEFITS
(Subart. added July 10, 2002, P.L.749, No.110)

Section 2431. Benefits.

(a) General rule.--A society authorized to do business in this Commonwealth may provide the following contractual benefits in any form:

(1) Death benefits.

(2) Endowment benefits.
(3) Annuity benefits.
(4) Temporary or permanent disability benefits.
(5) Hospital, medical or nursing benefits.
(6) Other benefits which are authorized for insurers licensed to write life, accident and health insurance and which are not inconsistent with this subarticle.

(b) Eligible members.--A society shall specify in its rules those persons who may be issued or covered by the contractual benefits in subsection (a), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(2431 added July 10, 2002, P.L.749, No.110)

Section 2432. Beneficiaries.

(a) Designation.--The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) Payment of funeral benefits.--A society may make provision for the payment of funeral benefits to the extent of that portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of $2,000.

(c) Absence of beneficiary.--If at the death of any person insured under a benefit contract there is no lawful beneficiary to whom the proceeds shall be payable, the amount of the benefit, except to the extent that funeral benefits may be paid as provided in this section, shall be payable to the personal representative of the deceased insured or, if none, then payment may be made in accordance with 20 Pa.C.S. § 3101(d) (relating to payments to family and funeral directors). If the owner of the certificate is other than the insured, the proceeds shall be payable to the owner.

(2432 added July 10, 2002, P.L.749, No.110)

Section 2433. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society shall be liable to attachment, garnishment or other process or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary or any other person who may have a right thereunder, either before or after payment by the society.

(2433 added July 10, 2002, P.L.749, No.110)

Section 2434. Benefit contract.

(a) General rule.--Every society authorized to do business in this Commonwealth shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided by the contract. The certificate, together with any riders or endorsements attached to it, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant and all amendments to each thereof, shall constitute the benefit contract as of the date of issuance between the society and the
owner, and the certificate shall so state. The society shall maintain a copy of its laws at each lodge for inspection by the benefit member and shall furnish a copy to each benefit member upon request. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Effect of subsequent changes.—Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as if the changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Effect on minority.—Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) Payment of deficiencies.—A society shall provide in its laws that, if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and if the payment is not made:

(1) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) in lieu of or in combination with paragraph (1), the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Certified copies as evidence.—Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) Content.—No certificate, application, rider or endorsement used in connection therewith shall be delivered or issued for delivery in this Commonwealth unless the form contains provisions required for like forms issued by life, accident and health insurers in this Commonwealth and a copy of the form has been filed with and approved by the commissioner in the manner provided for like policies issued by life, accident and health insurers in this Commonwealth. Every life, accident, health or disability insurance certificate, every annuity certificate and every application, rider or endorsement used in connection therewith approved prior to February 12, 1993, shall be brought into compliance with this subarticle by February 12, 1994.

(g) Premium grace period.—The certificate may contain a provision for a grace period for payment of premiums of one full month in its certificates.

(h) Additional provisions.—The certificate shall also contain the following:
(1) A provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which if violated will result in the termination or reduction of benefits payable under the certificate.

(2) A provision that any member expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(3) A provision that in case the age or sex of the member or of any other person is considered in determining the premium and it is found at any time before final settlement under the certificate that the age or sex has been misstated and the discrepancy and premium involved have not been adjusted, the amount payable under the certificate shall be such as the premium would have purchased at the correct age and sex. If the correct age was not an insurable age under the society's charter or laws, only the premiums paid to the society less any payments previously made to the member shall be returned, or, at the option of the society, the amount payable under the certificate shall be such as the premium would have purchased at the correct age according to the society's promulgated rates and any extension thereof based on actuarial principles.

(i) Transfer of control or ownership.--Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government and control of the certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to the transfer shall be specified in the certificate.

(j) Assignment.--A society may specify the terms and conditions on which benefit contracts may be assigned.

(2434 added July 10, 2002, P.L.749, No.110)

Section 2435. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

(a) Existing certificates.--For certificates issued prior to February 12, 1994, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to February 12, 1993.

(b) New certificates.--For life certificates issued after February 11, 1994, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table or the Commissioner's 1958 Standard Ordinary Mortality Table or the Commissioner's 1980 Standard Mortality Table or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this Commonwealth applicable to life insurers issuing policies containing like benefits based upon such tables. For annuity certificates issued after February 11, 1994, every paid-up annuity benefit, cash surrender value or death benefit
shall not be less than the corresponding amount in accordance with the laws of this Commonwealth applicable to life insurers issuing policies containing like benefits.
(2435 added July 10, 2002, P.L.749, No.110)

SUBARTICLE E
FINANCIAL
(Subart. added July 10, 2002, P.L.749, No.110)

Section 2441. Investments.
(a) General rule.--A society shall invest its funds only in investments authorized by the laws of this Commonwealth for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this Commonwealth which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated shall be held to meet the requirements of this section for the investment of funds.
(b) Real estate.--In addition to the investment of assets as prescribed in this section or any other laws of this Commonwealth, a fraternal benefit society may purchase, receive, hold and convey real estate or any interest therein for the purpose of maintenance or construction of camps or recreational areas with necessary facilities for all its members. These assets shall be shown on the annual statement at cost in the year acquired and may not exceed 5% of other admitted assets of the society.
(2441 added July 10, 2002, P.L.749, No.110)

Section 2442. Funds.
(a) General rule.--All assets shall be held, invested and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof except as provided in the benefit contract.
(b) Special funds.--A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.
(c) Separate accounts.--A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the insurance laws regulating life insurers establishing those accounts and issuing those contracts. To the extent the society deems it necessary in order to comply with any applicable Federal or State laws or any rules issued thereunder, the society may:
(1) Adopt special procedures for the conduct of the business and affairs of a separate account.
(2) For persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants and selection of a committee to manage the business and affairs of the account.
(3) Issue contracts on a variable basis to which section 2434(b) and (d) shall not apply.
(2442 added July 10, 2002, P.L.749, No.110)

SUBARTICLE F
REGULATION
(Subart added July 10, 2002, P.L.749, No.110)
Section 2451. Valuation.

(a) Existing certificates.--The minimum reserves for certificates issued prior to February 12, 1994, shall be those provided by the laws applicable immediately prior to February 12, 1993.

(b) New certificates.--The minimum reserves for certificates issued after February 11, 1994, shall be based on the following tables:

1. For certificates of life insurance - the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers.

2. For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for accident and health benefits - such tables as are authorized for use by life insurers in this Commonwealth.

(c) Valuation methods and standards.--All of the valuations under subsection (b) shall be under valuation methods and interest standards in accordance with the laws of this Commonwealth applicable to life insurers issuing policies containing like benefits.

(d) Other valuation standards.--The commissioner may, in his discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner may, in his discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by any society authorized to do business in this Commonwealth.

(e) Excess reserves.--Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

(2451 added July 10, 2002, P.L.749, No.110)

Section 2452. Reports.

(a) General rule.--Reports shall be filed in accordance with the provisions of this section.

(b) Annual statement.--Every society transacting business in this Commonwealth shall annually on or before March 1, unless for cause shown the time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year and shall pay the fee prescribed in section 2161 for the filing. The statement shall be in general form and context as approved by a national association of insurance commissioners, approved by the Insurance Department, for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(c) Valuation of certificates.--As part of the annual statement required in this section, each society shall on or before March 1 file with the commissioner a valuation of its certificates in force on December 31 last preceding. The commissioner may, in his discretion for cause shown, extend the time for filing the valuation for not more than two calendar months. The valuation shall be done in accordance with the
standards specified in section 2451. The valuation and underlying data shall be certified by a qualified actuary.

(d) Failure to file statement.--A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit $100 for each day during which that neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this Commonwealth shall cease while the default continues.

(2452 added July 10, 2002, P.L.749, No.110)

Section 2453. Annual license.

Societies which are now authorized to transact business in this Commonwealth may continue such business until April 1, 1993. The authority of such societies and all societies hereafter licensed may thereafter be renewed annually but in all cases to terminate on the succeeding April 1. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each license or renewal, the society shall pay the commissioner the prescribed fee. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this article.

(2453 added July 10, 2002, P.L.749, No.110)

Section 2454. Examination of societies.

(a) General rule.--The commissioner or any person he may appoint may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this Commonwealth in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the insurance laws regulating insurers shall also be applicable to the examination of societies.

(b) Payment of expenses.--The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued upon statements furnished by the commissioner.

(2454 added July 10, 2002, P.L.749, No.110)

Section 2455. Foreign or alien society; admission.

No foreign or alien society shall transact business in this Commonwealth without a license issued by the commissioner. Any such society desiring admission to this Commonwealth shall comply substantially with the requirements and limitations of this article applicable to domestic societies. Any such society may be licensed to transact business in this Commonwealth upon filing the following with the commissioner and upon a showing that its assets are invested in accordance with the provisions of this article:

(1) A duly certified copy of its articles of incorporation.
(2) A copy of its bylaws, certified by its secretary or corresponding officer.
(3) A power of attorney to the commissioner as prescribed in this article.
(4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country satisfactory to the commissioner.
(5) Certification from the proper official of its home state, territory, province or country that the society is
Section 2455. Injunction, liquidation and receivership of domestic society.

(a) Notice of deficiencies and sanctions.--When the commissioner upon investigation finds that a domestic society:

(1) has exceeded its powers;
(2) has failed to comply with any provision of this article;
(3) is not fulfilling its contracts in good faith;
(4) has a membership of less than 400 after an existence of one year or more;
(5) is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business; or
(6) has become impaired;

the commissioner shall notify the society of the deficiency or deficiencies and state in writing the reasons for his dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After this notice the society shall have a 30-day period in which to comply with the commissioner's request for correction, and, if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected or why an action in quo warranto should not be commenced against the society.

(b) Action by Attorney General.--If on that date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner may present the facts relating thereto to the Attorney General, who shall, if he deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) Hearing and order.--The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until all of the following occur:

(1) The commissioner finds that the violation complained of has been corrected.
(2) The costs of such action shall have been paid by the society if the court finds that the society was in default as charged.
(3) The court has dissolved its injunction.
(4) The commissioner has reinstated the certificate of authority.

(d) Liquidation.--If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.
(e) Validity of action and appointment of receiver.--No action under this section shall be recognized in any court of this Commonwealth unless brought by the Attorney General upon request of the commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as the receiver.

(f) Applicability to voluntary dissolution.--The provisions of this section relating to hearing by the commissioner, action by the Attorney General at the request of the commissioner, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

(2456 added July 10, 2002, P.L.749, No.110)
Section 2457. Suspension, revocation or refusal of license of foreign or alien society.

(a) Notice of deficiencies and sanctions.--When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this Commonwealth:

(1) has exceeded its powers;
(2) has failed to comply with any of the provisions of this article;
(3) is not fulfilling its contracts in good faith; or
(4) is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice, the society shall have a 30-day period in which to comply with the commissioner's request for correction, and, if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on that date the society does not present good and sufficient reason why its authority to do business in this Commonwealth should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this Commonwealth until satisfactory evidence is furnished to the commissioner that the suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this Commonwealth.

(b) Existing contracts unaffected.--Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this Commonwealth during the time the society was legally authorized to transact business in this Commonwealth.

(2457 added July 10, 2002, P.L.749, No.110)
Section 2458. Injunction.
No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, respecting any matter pertaining to a regulatory law administered by the commissioner shall be recognized in any court of this Commonwealth unless made by the Attorney General upon request of the commissioner.

(2458 added July 10, 2002, P.L.749, No.110)
Section 2459. Licensing of agents.
(a) General rule.--Agents of societies shall be licensed in accordance with the insurance laws regulating the licensing, revocation, suspension or termination of license of resident and nonresident agents.
(b) Exemptions from licensure.--No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Examination.--

(1) Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of $200,000 or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than 25 individuals and who has received or will receive a commission or other compensation therefor shall be required to take an examination. No examination shall be required of any agent who was in the service of a society on January 28, 1978.

(2) Beginning July 1, 2007, and every five years thereafter, the commissioner shall review the monetary limit contained in this subsection and may adjust the amount. The adjustment shall not exceed the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) for the Pennsylvania, New Jersey, Delaware and Maryland area, officially reported by the United States Department of Labor, Bureau of Labor Statistics, for the period since the last adjustment under this subsection. Any adjustment to the amount shall be published as a notice in the Pennsylvania Bulletin.

(d) Limitation.--No society doing business in this Commonwealth shall pay any commission or other compensation to any person for any services in obtaining in this Commonwealth any new contract of life, accident or health insurance or any new annuity contract, except to a licensed fraternal insurance agent of that society.

(2459 added July 10, 2002, P.L.749, No.110)

Section 2460. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this Commonwealth shall be subject to the provisions of the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act, but nothing in that act shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership by reason of common bond or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization organized to carry out the purposes set forth in section 2406(a)(2).

(2460 added July 10, 2002, P.L.749, No.110)

Section 2461. Fees.

The commissioner shall charge and collect fees from fraternal benefit societies as set forth in section 612-A of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929. All fees collected shall be paid daily into the State Treasury.

(2461 added July 10, 2002, P.L.749, No.110)

Section 2462. Taxation.

Every society organized or licensed under this article is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every
Commonwealth, county, district, municipal and school tax other than taxes on real estate and office equipment.

(2462 added July 10, 2002, P.L.749, No.110)

Section 2463. Review.

All decisions and findings of the commissioner made under the provisions of this article shall be subject to review by proper proceedings in any court of competent jurisdiction in this Commonwealth.

(2463 added July 10, 2002, P.L.749, No.110)

Section 2464. Penalties.

(a) False statements.--It shall be prohibited for any person to willfully make a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society.

(b) Filing of false statement.--Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this article or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for the purpose of procuring payment of a benefit named in the certificate commits perjury and shall be subject to the penalties therefor prescribed by law.

(c) Solicitation by nonlicensed society.--A person who solicits membership for or in any manner assists in procuring membership in any society not licensed to do business in this Commonwealth commits a summary offense and shall, upon conviction, be sentenced to pay a fine of not less than $500 nor more than $1,000.

(d) Penalty for other violation.--A person who willfully violates, neglects or refuses to comply with the provisions of this article for which a penalty is not otherwise prescribed commits a summary offense and shall, upon conviction, be sentenced to pay a fine of not more than $500. Upon satisfactory evidence of a violation of any provision of this article, the commissioner has the discretion, in lieu of seeking criminal prosecution, to pursue any one or more of the following courses of action:

1. Suspend or revoke or refuse to renew the license of the offending party or parties.
2. Impose a civil penalty of not more than $5,000 for each act in violation of the provisions of this article.

(2464 added July 10, 2002, P.L.749, No.110)

Section 2465. Applicability of insurance laws.

Except as provided in this article, societies shall be governed by this article and shall be exempt from all other provisions of the insurance laws of this Commonwealth unless they are expressly designated therein or unless it is specifically made applicable by this article.

(2465 added July 10, 2002, P.L.749, No.110)

Section 2466. Exemption of certain societies.

(a) General rule.--Nothing contained in this article shall be so construed as to affect or apply to:

1. Grand or subordinate lodges of societies, orders or associations now doing business in this Commonwealth which provide benefits exclusively through local or subordinate lodges.
2. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations.
(3) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any one year, or both.

(4) Domestic societies or associations of a purely religious, charitable or benevolent description which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to any one person in any one year, or both.

(b) Exclusions from exemption.--Any society or association described in subsection (a)(3) or (4) which provides for death or disability benefits for which benefit certificates are issued and any society or association included in subsection (a)(4) which has more than 1,000 members shall not be exempted from the provisions of this article but shall comply with all requirements thereof.

(c) Limitation or compensation payments.--No society which, by the provisions of this section, is exempt from the requirements of this article, except any society described in subsection (a)(2), shall give or allow or promise to give or allow to any person any compensation for procuring new members.

(d) Accidental benefits.--Every society which provides for benefits in case of death or disability resulting solely from accident and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this subarticle except that the provisions thereof relating to medical examination, valuations of benefit certificates and incontestability shall not apply to such society.

(e) Submission of information.--The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from the provisions of this subarticle.

(f) Exemption from insurance laws.--Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this Commonwealth.

(2466 added July 10, 2002, P.L.749, No.110)

ARTICLE XXV
COMMUNITY HEALTH REINVESTMENT
(Art. added July 9, 2008, P.L.885, No.62)

Compiler's Note: See sections 11 and 12 of Act 62 of 2008 in the appendix of this act for special provisions relating to mergers, consolidations or other acquisitions of control.

Section 2501. Definitions.
The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:
"Community health reinvestment activity." Community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following:

(1) Health care coverage for persons who are determined by recognized standards as determined by the Insurance Department to be unable to pay for coverage.
(2) Health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services.

(3) Programs for the prevention and treatment of disease or injury, including mental retardation, mental disorders, mental health counseling or the promotion of health or wellness.

The term shall not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with State health care programs, programs provided as an employee benefit, use of facilities for meetings held by community groups or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Department." The Insurance Department of the Commonwealth. "Plan." A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(2501 added July 9, 2008, P.L.885, No.62)

Section 2502. Duties of plan and department.

(a) Plan duties.--A plan shall have the following duties:

(1) To submit a proposal to the department on or before March 30 of each year setting forth the manner in which the plan will provide proposed community health reinvestment activities conducted or provided by the plan during the next fiscal year.

(2) To annually provide to the department, the Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives the name and address of each officer, director or employee who serves on the board of directors of a hospital or other health care facility as defined in section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or on the board of an entity that owns, operates or manages a hospital or other health care facility. This paragraph shall apply to a nonprofit or for-profit subsidiary or affiliate of a hospital plan corporation or professional health services plan corporation. The information shall be submitted by January 31 for the immediately preceding year.

(b) Department duties.--The department shall have the following duties:

(1) To develop a form which shall be used by each plan for the submission of the proposal under subsection (a)(1). The form shall require the itemization of individual community health reinvestment activities and the cost of each activity under the Agreement on Community Health Reinvestment entered into February 2, 2005, by the Insurance Department and Capital Blue Cross, Highmark, Inc., the Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross and published at 35 Pa.B. 4155 or any successor or other agreements. The proposal shall be on a form published by the department in the Pennsylvania Bulletin.

(2) To approve or disapprove the expenditures in the proposal submitted under subsection (a)(1).

(2502 added July 9, 2008, P.L.885, No.62)

Section 2503. Public record.

All proposals submitted under section 2502 shall be public records.

(2503 added July 9, 2008, P.L.885, No.62)

Section 2504. Regulations.
The department may promulgate regulations as necessary for the administration of this article.
(2504 added July 9, 2008, P.L.885, No.62)

ARTICLE XXVI
RISK MANAGEMENT AND OWN RISK SOLVENCY ASSESSMENT
(Art. added Oct. 25, 2013, P.L.656, No.78)

Section 2601. Purpose and scope of article.
(a) Purpose.--The purpose of this article is to:
(1) Require an insurer or insurance group to maintain a risk management framework and complete an own risk and solvency assessment (ORSA).
(2) Set forth the requirements for filing an ORSA summary report with the Insurance Department.
(3) Provide for the confidential treatment of the ORSA, the ORSA summary report and other ORSA-related information, which contain trade secrets and other proprietary information that, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.
(b) Scope.--The requirements of this article shall apply to all insurers domiciled in this Commonwealth unless exempt under section 2606.
(2601 added Oct. 25, 2013, P.L.656, No.78)

Section 2602. Definitions.
The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:
"Commissioner." The Insurance Commissioner of the Commonwealth.
"Department." The Insurance Department of the Commonwealth.
"Insurance group." The insurers and affiliates included within an insurance holding company system as defined in section 1401.
"Insurer." Any fraternal benefit society, health maintenance organization, preferred provider organization, company, association, exchange, hospital plan corporation as defined in and subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), authorized by the Insurance Commissioner to transact the business of insurance in this Commonwealth except that the term shall not include:
(1) the Commonwealth or any agency or instrumentality thereof; or
(2) agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision.
"NAIC." The National Association of Insurance Commissioners or successor organization and its affiliates and subsidiaries.
"ORSA guidance manual." The current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the NAIC and as amended. A change in the ORSA guidance manual will be effective on January 1 following the calendar year in which the change was adopted by the NAIC.
"ORSA-related information." The ORSA, ORSA summary report, risk management framework or any documents, materials or other information related to an insurer or insurance group's ORSA, ORSA summary or risk management framework.
"ORSA summary report." The confidential high-level summary of an insurer or insurance group's ORSA.
"Own risk and solvency assessment" or "ORSA." A confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(2602 added Oct. 25, 2013, P.L.656, No.78)

Section 2603. Risk management framework.
An insurer shall maintain a risk management framework for identifying, assessing, monitoring, managing and reporting its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

(2603 added Oct. 25, 2013, P.L.656, No.78)

Section 2604. ORSA requirement.
An insurer, or the insurance group of which the insurer is a member, shall conduct an ORSA consistent with the guidelines set forth in the ORSA guidance manual. The ORSA shall be conducted regularly, but no less frequently than annually, and at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

(2604 added Oct. 25, 2013, P.L.656, No.78)

Section 2605. ORSA summary report.
(a) General rule.--Beginning January 1, 2015, and every year thereafter, a domestic insurer or an insurer that is a member of an insurance group of which Pennsylvania is the lead state as determined by the financial analysis handbook adopted by the NAIC shall submit an ORSA summary report to the department once per calendar year. The insurer or insurance group shall determine the most appropriate date of filing based upon the insurer or insurance group's internal strategic planning processes and notify the department of the anticipated date of filing by June 1 of each year.

(b) Exception.--An insurer not required to submit an ORSA summary report under subsection (a) shall do so upon the department's request, but not more than once per calendar year. The insurer shall determine the most appropriate date of the filing based upon the insurer's internal strategic planning processes and notify the department of the anticipated date of filing within 30 days of the department's request.

(c) Form of summary report.--An insurer may comply with subsection (a) or (b) by providing to the department either of the following:

(1) A combination of reports that together contain the information described in the ORSA guidance manual.

(2) A copy of the most recent reports submitted by the insurer, or another member of an insurance group of which the insurer is a member, to the chief insurance regulatory official of another state or to a supervisor or regulator of a foreign jurisdiction, if that report is substantially similar to the ORSA summary report. For purposes of this section, "substantially similar" means containing information comparable to the information described in the ORSA guidance manual as determined by the commissioner. If the report is in a language other than English, it must be accompanied by a translation of that report into the English language.

(d) Attestation.--The ORSA summary report must include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of
the insurer's risk management process attesting to the best of that person's belief and knowledge that the insurer applies the risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(e) Compliance with ORSA guidance manual.--The ORSA summary report must be prepared in accordance with the ORSA guidance manual. Documentation and supporting information must be maintained and made available upon request in an examination conducted pursuant to section 1406 or Article IX of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

(f) Review by department.--The department shall review the ORSA summary report and make additional requests for information using procedures similar to current procedures for coordinating analysis and examination of multistate or global insurers and insurance groups.

(g) Summary of material changes and updates.--The ORSA summary report should also include a short summary of material changes and updates to the ORSA summary report since the prior year.

(2605 added Oct. 25, 2013, P.L.656, No.78)

Section 2606. Exemption.

(a) General rule.--An insurer is exempt from the requirements of this article, if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(2) the insurer is a member of an insurance group, the insurance group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(b) Partial exemption for insurer.--If an insurer is exempt under subsection (a)(1), but the insurance group of which the insurer is a member is not exempt under subsection (a)(2), then the ORSA summary report must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers if the reports include every insurer within the insurance group.

(c) Partial exemption for insurance group.--If an insurer is not exempt under subsection (a)(1), but the insurance group of which the insurer is a member is exempt under subsection (a)(2), then the insurer shall file the ORSA summary report applicable only to the insurer.

(d) Waiver.--An insurer that is not exempt under subsection (a) may apply to the commissioner for a waiver from the requirements of this article based upon unique circumstances. If the insurer is a member of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver. In deciding whether to grant the insurer's request for a waiver, the commissioner may consider:

(1) The type and volume of business written.

(2) Ownership and organizational structure.

(3) Material reduction in risk or risk exposures.
(4) Any other factor the commissioner determines to be relevant to whether a waiver should be granted.

(e) Additional requirements.--Notwithstanding the exemptions under subsection (a):

(1) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report based on unique circumstances, including the type and volume of business written, ownership and organizational structure, Federal agency requests and international supervisor requests. If the commissioner requires an insurer to maintain a risk management framework, conduct an ORSA and file an ORSA summary report under this paragraph, the insurer shall have one year after receiving written notice to comply with the requirement.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report if the insurer:

(i) has risk-based capital for a company action level event as set forth in sections 506-A and 505-B of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921;

(ii) meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in 31 Pa. Code Pt. VIII Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition); or

(iii) otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(3) If an insurer exempt under subsection (a) no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

(2606 added Oct. 25, 2013, P.L.656, No.78)

Section 2607. Third-party consultants.

(a) Authorization.--The department may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the department's staff as may be reasonably necessary to assist the department in reviewing the risk management framework, ORSA, ORSA summary report or the insurer's compliance with this article.

(b) Control.--Any persons retained under subsection (a) shall be under the direction and control of the department and shall act in a purely advisory capacity.

(c) Confidentiality.--Third-party consultants shall be subject to the same confidentiality standards and requirements as the department.

(d) Verification.--As part of the retention process, a third-party consultant shall verify to the department, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this act.

(e) Written consent.--A retention agreement with a third-party consultant shall expressly require the written consent of the insurer prior to making public information provided under this act, as required under section 2608(a).

(2607 added Oct. 25, 2013, P.L.656, No.78)

Section 2608. Confidentiality.
(a) General rule.--The ORSA-related information in the possession of or the control of the department that is produced by, obtained by or disclosed to the department or any other person under this article shall be privileged and given confidential treatment and shall not be:

1) Subject to discovery or admissible as evidence, in a private civil action.
2) Subject to subpoena.
3) Subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.
4) Made public by the department or any other person without the prior written consent of the insurer to which it pertains, except as provided in subsection (c).

(b) Private civil actions.--The commissioner, department or any individual or person who receives ORSA-related information while acting under the authority of the commissioner or department or with whom the ORSA-related information is shared pursuant to this article shall not be permitted or required to testify in any private civil action concerning the ORSA-related information.

(c) Use of ORSA-related information by the department.--To assist in the performance of regulatory duties, the department:

1) May use ORSA-related information in furtherance of any regulatory or legal action brought as part of the department's official duties.
2) May share ORSA-related information with the NAIC, regulatory or law enforcement officials of this Commonwealth or other jurisdictions, group supervisors, members of any supervisory college under section 1406.1 and with third-party consultants under section 2607, provided that, prior to receiving the ORSA-related information, the recipient demonstrates by written statement the necessary authority and intent to provide the same confidential treatment as required by this article.
3) May receive and maintain as confidential ORSA-related information from the NAIC, regulatory or law enforcement officials of this Commonwealth or other jurisdictions, group supervisors and members of any supervisory college under section 1406.1 in which the ORSA-related information is confidential by law in those jurisdictions. ORSA-related information obtained under this paragraph shall be given confidential treatment, may not be subject to subpoena and may not be made public by the department, commissioner or any other person.

(d) Written agreements.--The department shall enter into written agreements with the NAIC or a third-party consultant governing sharing and use of information provided under this article that includes all of the following:

1) Specific procedures and protocols for maintaining the confidentiality and security of ORSA-related information.
2) Procedures and protocols for sharing ORSA-related information with regulators from other states in which the insurance group has domiciled insurers, including a written acknowledgment of the recipient's intent and legal authority to maintain the confidential and privileged status of the ORSA-related information.
3) A provision specifying that ownership of the ORSA-related information shared remains with the department and that the use of the ORSA-related information is subject to the direction and approval of the department.
(4) A provision that prohibits storing, in a permanent database after the underlying analysis is completed, ORSA-related information shared pursuant to this article.

(5) A provision requiring the NAIC or third-party consultant, where permitted by law, to give prompt notice to the department and to the insurer regarding any subpoena, request for disclosure or request for production of the insurer's ORSA-related information in the possession of the NAIC or third-party consultant.

(6) A requirement that the NAIC or third-party consultant would consent to intervention by an insurer in any judicial or administrative action in which the NAIC or third-party consultant may be required to disclose ORSA-related information or other confidential information about the insurer or insurance group that was shared under this article.

(e) No delegation.--The sharing of information by the department under this article shall not constitute a delegation of regulatory authority or rulemaking. The department is solely responsible for the administration, execution and enforcement of this article.

(f) No waiver of privilege or confidentiality.--The sharing of ORSA-related information with, to or by the department as authorized by this article shall not constitute a waiver of any applicable privilege or claim of confidentiality.

(g) Information with third parties.--ORSA-related information in the possession or control of the NAIC or a third-party consultant as provided under this article shall:

1. Be confidential and privileged.
2. Not be subject to the Right-to-Know Law.
3. Not be subject to subpoena.
4. Not be subject to discovery or admissible as evidence, in any private civil action.

(2608 added Oct. 25, 2013, P.L.656, No.78)

Section 2609. Sanctions.

An insurer that fails to timely file an ORSA summary report as required under this article or by regulation shall be required to pay a penalty of $200 for each day of delay. The maximum penalty under this section is $25,000 per year.

(2609 added Oct. 25, 2013, P.L.656, No.78)

Section 2610. Regulations.

The department may promulgate rules and regulations and issue such orders as are necessary to administer and enforce this article.

(2610 added Oct. 25, 2013, P.L.656, No.78)

ARTICLE XXVII
QUALITY EYE CARE FOR INSURED PENNSYLVANIANS
(Art. added Oct. 24, 2018, P.L.681, No.103)

Section 2701. Short title of article.

This article shall be known and may be cited as the Quality Eye Care for Insured Pennsylvanians Act.

(2701 added Oct. 24, 2018, P.L.681, No.103)

Section 2702. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Covered vision care." Vision services and materials for which reimbursement is available under a health insurance policy, regardless of whether the reimbursement is contractually limited by a deductible, copayment, coinsurance, waiting period,
annual or lifetime maximum, frequency limitation or alternative benefit payment.

"Department." The Insurance Department of the Commonwealth.

"Health insurance policy." An individual or group health insurance policy, subscriber contract, certificate or plan issued by or through an insurer that provides covered vision care. The term does not include accident only, fixed indemnity, limited benefit, credit, dental, specified disease, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

"Health insurer." An entity licensed by the department with accident and health authority to issue a policy, subscriber contract, certificate or plan that provides medical or health care coverage and is offered or governed under any of the following:

(1) Section 630, Article XXIV or other provision of this act.
(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Insured." An individual on whose behalf a health insurer is obligated to pay for vision care under a health insurance policy.

"Materials." Ophthalmic devices, including, but not limited to, lenses, devices containing lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coating, contact lenses and prosthetic devices to correct, relieve or treat defects or abnormal conditions of the human eye or its adnexa associated with the delivery of vision care.

"Noncovered services." Vision care that is not covered but for which a discount may be provided under the terms of a health insurance policy.

"Vision care." Provision of eye care services, materials or both.

"Vision care provider." A licensed doctor of optometry practicing under the authority of the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act, or a licensed physician who has also completed a residency in ophthalmology.

"Vision care supplier." A person or entity that creates, promotes, sells, provides, advertises or administers vision care supplies, including an optical laboratory. The term includes persons or entities affiliated with a health insurer.

(2702 added Oct. 24, 2018, P.L.681, No.103)

Section 2703. Vision care provider and vision care supplier selection.

A health insurance policy shall allow an insured who receives vision care from an in-network vision care provider to select an out-of-network vision care supplier for related vision care on the recommendation or referral of the in-network vision care provider, provided that the in-network vision care provider gives to the insured, prior to recommending, referring, prescribing or ordering any vision care from the out-of-network vision care supplier, written notice that:

(1) The out-of-network vision care supplier is not an in-network vision care supplier.
(2) The insured has the option of selecting an in-network vision care supplier.
(3) The insured may have different financial obligations depending on whether the vision care supplier is in-network or out-of-network.

(2703 added Oct. 24, 2018, P.L.681, No.103)

Section 2704. Discount access.
A health insurance policy that has a discount program for noncovered services shall permit an insured who receives vision care from an in-network vision care provider to receive a noncovered service from the in-network vision care provider at a nondiscounted rate, provided that the vision care provider gives to the insured, prior to receipt of the noncovered service, written disclosure that the vision care provider does not participate in the insured's discount program.

(2704 added Oct. 24, 2018, P.L.681, No.103)

Section 2705. Enforcement.
(a) Scope.--The department may investigate and enforce the provisions of this article only insofar as the actions or inactions being investigated relate to coverage under a health insurance policy.

(b) Insurance Commissioner power.--Upon satisfactory evidence of a violation of this article by any insurer or other person within the scope of the department's investigative and enforcement authority under subsection (a), the Insurance Commissioner may, in the Insurance Commissioner's discretion, pursue any of the following actions:

(1) Suspend, revoke or refuse to renew the license of the offending person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than $5,000 for each action in violation of this article.

(4) Impose a civil penalty of not more than $10,000 for each action in willful violation of this article.

(c) Limitation.--Penalties imposed under this article shall not exceed $500,000 in the aggregate during a calendar year.

(d) Violations by optometrists and ophthalmologists.--A violation of this article by an optometrist shall constitute unprofessional conduct under the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act. A violation of this article by an ophthalmologist shall constitute unprofessional conduct under the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

(2705 added Oct. 24, 2018, P.L.681, No.103)

Section 2706. Regulations.
The department may promulgate regulations as may be necessary or appropriate to implement this article.

(2706 added Oct. 24, 2018, P.L.681, No.103)

Section 2707. Applicability.
This article shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the department, this article shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the department, this article shall apply to any policy issued or renewed on or after 180 days after the effective date of this section.

(2707 added Oct. 24, 2018, P.L.681, No.103)
Section 16. Pursuant to section 654, act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," each filing for rate changes due to the provisions of The Pennsylvania Workmen's Compensation Act or any subsequent increase in compensation payable or based upon experience shall be on file for a waiting period of thirty days with the Insurance Department before it becomes effective, which period may be extended by the Insurance Commissioner for one additional period not to exceed thirty days upon written notice within such waiting period to the insurer or rating organization which made the filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing of a part thereof which he has reviewed to become effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of this act and to become effective upon the termination of the thirty-day waiting period or an extension thereof unless disapproved, amended or modified by the commissioner within the waiting period or an extension thereof. The provisions of this section shall not be deemed to supersede the provisions of "The Insurance Company Law of 1921" in so far as such provisions are not expressly inconsistent.

Section 3. Existing insurance companies presently writing workmen's compensation insurance policies shall be required to meet the minimum capital stock and other financial requirements of this act within five years from the effective date hereof.

Compiler's Note: Act 184 amended sections 202 and 206 of Act 284.

Section 4. Existing insurance companies presently authorized to write workmen's compensation insurance pursuant to section 202(c)(4) amended by this act shall continue to retain such authority hereafter, subject to compliance with section 3 of this amendatory act.

Section 11. This act shall not apply to any merger, consolidation or other acquisition of control completed or consummated prior to the effective date of this section and, if required, following the issuance of an approving determination.

Compiler's Note: Act 62 amended or added sections 108, 405.2, 635.2, 635.3, 1401, 1402, 1403, 1403.1, 1403.2 and 1405 and Article XXV of Act 284.
Section 12. This act shall apply to any application, statement or other plan or proposal relating to a merger, consolidation or other acquisition of control filed with the Insurance Department on or after January 1, 2007.

2015, DECEMBER 20, P.L.461, NO.84

Section 4. The addition of Article XXIII-A of the act is a continuation of former Article XXIII of the act. The following apply:

(1) Except as otherwise provided in Article XXIII-A of the act, all activities initiated under former Article XXIII of the act shall continue and remain in full force and effect and may be completed under Article XXIII-A. Orders, regulations, rules and decisions which were made under former Article XXIII and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under Article XXIII-A. Contracts and obligations entered into under former Article XXIII are not affected nor impaired by the repeal of Article XXIII.

(2) Except as set forth in paragraph (3), any difference in language between Article XXIII-A and former Article XXIII is intended only to conform to style and is not intended to change or affect the legislative intent, judicial construction or administration and implementation of former Article XXIII.

(3) Paragraph (2) does not apply to the addition of the following provisions:

(i) The change in the definition of "department" in section 2301-A of the act.
(ii) The provisions for arrangements with other agencies under section 2302-A(f)(2)(vii) of the act.
(iii) The expiration provision under section 2309-A of the act.
(iv) The addition of paragraphs (d)(5) and (e)(3) of section 2302-A of the act regarding the exclusion of costs related to the managed care organization assessments under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.
(v) The addition of subparagraph (a)(3)(iv) of section 2304-A of the act regarding the determination of the amount of the contract.

(4) All entities receiving grants under former Article XXIII on the effective date of this section shall continue to receive funds and provide services as required under former Article XXIII until notice from the Department of Human Services is published in the Pennsylvania Bulletin.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: Act 84 added sections 635.7 and 2007.1, repealed Article XXIII and added Article XXIII-A.

2016, JULY 8, P.L.474, NO.73

Section 2. The addition of section 631.1 of the act applies as follows:
(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, section 631.1 of the act shall apply to any such policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, section 631.1 of the act shall apply to any such policy issued or renewed on or after 180 days after the effective date of this section.

Compiler's Note: Act 73 added section 631.1.

2018, OCTOBER 24, P.L.681, NO.103

Section 3. The amendment of section 2116 of the act shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Federal Government or the Insurance Department, this section shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Federal Government or the Insurance Department, this section shall apply to any policy issued or renewed on or after 180 days after the effective date of this section.

Compiler's Note: Act 103 amended or added section 2116 and Article XXVII.