FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
Materials Available on the Web at:
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October 17, 2017

MEMBERS
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jimmy Patronis
Commissioner Adam Putnam

Contact: **Caitlin Murray**
(850-413-5005)

8:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for August 16, 2017.

   http://www.myflorida.com/myflorida/cabinet/agenda17/0816/transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Hurricane Irma Update

   (ATTACHMENT 2) **INFORMATIONAL**

3. Request for Approval of the Office of Insurance Regulation to Contract with the Proposed Consultant to Conduct the Workers' Compensation Peer Review.

   Section 627.285, F.S., requires that the Financial Services Commission contract, at least once every other year, for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance in Florida.

   The National Council on Compensation Insurance (NCCI) is responsible for collecting statistical information and making workers' compensation rate filings on behalf of Florida's insurers. By law, the contract requires the submission of a final report to the Commission, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2018.

   The Office has conducted the formal solicitation process by way of Request for Quote (RFQ). In order to meet this statutory requirement, it is recommended that the Office, on behalf of the Financial Services Commission, enter into the attached agreement with EVP Advisors, Inc. to perform the required peer review.

(ATTACHMENT 3) **FOR APPROVAL**

4. Request for Approval for Final Adoption of Repeal of Rules 69O-154.110,.111; Certificate of Creditable Coverage; Demonstration of Creditable Coverage If Certificate is not Provided;

   These two rules are being repealed due to a change in the governing statute that no longer requires insurers to provide a certificate of creditable coverage.

   (ATTACHMENT 4) **APPROVAL FOR FINAL ADOPTION**

5. Request for Approval for Final Adoption of Repeal of Rule 69O-149.204; Outline of Coverage

   This rule is being repealed due to a change in the statute no longer requires an insurer to offer a Standard Health Benefit Plan.

   (ATTACHMENT 5) **APPROVAL FOR FINAL ADOPTION**

6. Request for Approval for Final Adoption of Rules 69O-162.008,.012; Contract Provision, Expense, Mortality and Investment Increment Factor; Valuation of Account Assets; Reserve Liability

   Amend rules to refer to updated Annuity Mortality Tables for individual and group annuity contracts.

   (ATTACHMENT 6) **APPROVAL FOR FINAL ADOPTION**

7. Office of Insurance Regulation 4th Quarter Report FY 2016-17

   (ATTACHMENT 7) **FOR APPROVAL**

OFFICE OF INSURANCE REGULATION

GOVERNOR SCOTT: Next I'd like to recognize David Altmaier with the Office of Insurance Regulation.

Good morning.

COMMISSIONER ALTMAIER: Good morning, Governor. Cabinet members, good morning, CFO, Commissioner, Attorney General. It's great to be here this morning.

It looks like a long agenda. I think we could get there relatively quickly though.

The first item up is the approval of the minutes from the Financial Services Commission from June the 14th. We'd respectfully request your approval of those minutes.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

CFO PATRONIS: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion

carries.

COMMISSIONER ALTMAIER: Thank you very much.

Item Number 2 is a request for approval for final adoption of the repeal of Rule 69O-125.002, which is for unfair discrimination of insurance rates for multi-policy discounts. This is a rule that is now codified in statute, so the rule is now obsolete. We've gone through the publication process, and it's now ready for final adoption. So we'd respectfully request your permission for the final adoption of Agenda Item Number 2.

GOVERNOR SCOTT: Is there a motion on the item?

CFO PATRONIS: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you -- excuse me. Thank you very much.

For Agenda Items Number 3 and 4, I apologize, these are not quite ready; and I'd respectfully request that we withdraw Agenda Items Number 3 and

4 and bring them back at a later date.

GOVERNOR SCOTT: Is there a motion to withdraw Items 3 and 4?

COMMISSIONER PUTNAM: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

If it's okay with you, Governor and Cabinet, Items 5, 6, and 7 we could probably do together. They are the approval for publication of several rules.

Item Number 5 is the approval for publication of the repeal of several rules that are no longer applicable due to change in statutes.

Item Number 6, very similar, it's approval for publication of the repeal of a rule no longer required due to a change in statute.

And Item Number 7 is approval for the publication of a rule that makes some technical changes to the mortality and investment incremental factors. These are tables that companies use when they make their rate filings for annuity contracts. And so we are going to begin the repeal process for

two of those and the amendment process for the third one, and so I would respectfully request your approval to publish the rules listed in Items 5, 6 and 7.

GOVERNOR SCOTT: Is there a motion on Items 5, 6, 7?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

So now we will move to Agenda Item Number 8. This is an item that we've talked to the Cabinet. We've spent a lot of time with each of your staffs on this item.

We are proposing new performance measures for the Office of Insurance Regulation. We have a slide in your materials that I've put on the screen which demonstrates what they are.

We've spent a lot of time working on this. The goal for the new performance measures is to increase the efficiency at which the Office of

Insurance Regulation conducts its business without sacrificing the quality that our team puts into the work that they do. We believe that these measures will encourage us to be more expeditious when we are protecting consumers, when we are bringing companies and jobs into our marketplace, and when we are allowing companies to bring their products to our market.

And so as I mentioned, I'm happy to answer any questions about these new performance measures that are on the screen before you but would respectfully request your permission to approval those.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And so that brings us to our last agenda item, which is Agenda Item Number 9, which is our legislative budget request as well as our

legislative priorities for 2018.

So our legislative budget request is relatively straightforward. We are requesting a continuation budget. There are some details about our budget currently on the slide in front of you. We continue to have 289 full-time positions, a budget of just over 30 million. There are some specific details here with respect to this year's budget versus next year's budget which we would just ask that it remain the same.

And so we would submit that to you as our legislative budget request. If you'd like for me to pause there so you can deal with that, I'm happy to; or I can go ahead and talk about our legislative priorities.

GOVERNOR SCOTT: Does anybody have any questions?

(NO RESPONSE).

GOVERNOR SCOTT: Nope. Go ahead.

COMMISSIONER ALTMAIER: Okay.

Our legislative priorities are also very straightforward, although very challenging as well. Our legislative priority this year is to continue our efforts on our assignment of benefits problem. This is an issue that I've spent a lot of time

talking with each of you and with each of your staffs about.

We made solid effort last session. Unfortunately, we were not able to get a piece legislation across the finish line. We have continued to work very hard in what we are calling "halftime," in between the past legislative session and this legislative session, to assess a strategy going forward, as well as look at other administrative opportunities that we have to address the rising costs due to what we view as excessive litigation related to assignment of benefits.

From a legislative standpoint, we continue to believe that the attorney-fee framework that exists in Florida encourages the excess lit -- the excessive litigation that we're currently seeing, which is driving up rates for consumers. And so we view this as the Number 1 issue from an insurance regulatory standpoint that are impacting the rates that consumers pay for their homeowners insurance, and we are going to work very hard at addressing this issue this coming legislative session.

And so that will be our primary focus for this

legislative session. I'm happy to take any questions that you might have.

GOVERNOR SCOTT: Commissioner.

COMMISSIONER PUTNAM: What can be done, and what are you doing within the existing authority of the Office that does not require statutory changes to deal with this problem?

COMMISSIONER ALTMAIER: Thank you, Commissioner.

We had mentioned at the last Cabinet meeting that we were looking at several policy form changes. I'm happy to inform you that yesterday we signed off on a policy form change for Citizens. Of course Citizens continues to be a major player in our marketplace. They've got well over 400,000 polices. This policy form change would look to stem the tide of excessive litigation.

It will take a little bit of time for those policy forms to get their way into the marketplace. We expect that now that they are approved for Citizens that a number of other private carriers can adopt those forms for their own use.

We have a number of other ideas that are on the table in various stages of completion, ideas that other private companies have brought to us as

policy form changes that would work to address this issue. They will be helpful, in my opinion, in curbing some of these losses. I don't believe that they would be as effective as a legislative change would be, and so that's why we continue to work along two parallel work streams, doing what we can administratively through policy form change process, as well as trying to take the incentive out of the marketplace legislatively, which would be the attorney-fee framework.

COMMISSIONER PUTNAM: Thank you.

CFO PATRONIS: Thank you, Governor.

And thank you for your comments and presentation.

My concerns are with the epidemic with assignment of benefits. It's definitely localized right now, but it's localized in a heavily populated area part of our state, and it is what it is. I think when individuals are taken advantage of, these circumstances, they know what they're taken advantage of sounds too good to be true.

And my concerns are, is that they probably -- they understand it's too good to be true. But when I was down in Broward County last week, there's

billboards, there's radio advertisements, there are these enticements out there that are feeding the frenzy.

These individuals that are taking the assignment of benefits' approach in getting a new kitchen, what are you doing on behalf of just education and outreach to let them know that this is wrong? I mean my -- I feel like at the end of the day you're our authority on insurance in the state.

My concern is educating a population out there that they are taking advantage of a system, and these are the policyholders that are taking advantage of a system, and maybe unknowingly. But again, you can't tell me that these individuals don't understand the gravity that they're getting something they shouldn't be getting in the circumstances or the manner that they're getting.

COMMISSIONER ALTMAIER: Certainly, CFO, and great comments and great question. I appreciate it very much.

We have drafted some bulletins that we have used, primarily when Hurricane Matthew and Hurricane Hermine were approaching the state. We were concerned at that time that we would see a

significant increase in the number of people that were taken advantage of through this process.

And so we drafted some bulletins that we sent out that reminded consumers that while they have the option to sign an assignment, they're not required to sign an assignment. There are certain pitfalls that can arise when you do that.

We also know that Citizens has a significant education program that they are also working with their agents. We're working closely with the agent community, which is oftentimes the first call that consumers get. A lot of times when you ask a consumer who their insurance company is, they'll tell you it's so and so insurance agency down the street, and so that's their relationship.

So we're working very closely with the agent community who seem to be very onboard with this issue. They view it as a problem that's in the marketplace and are very good resources in terms of educating consumers with respect to the pitfalls of the assignment-of-benefit mechanism.

And while it might sound good at first, there are certainly pitfalls for consumers by going down that process, and we want to make sure that they're very mindful of those. So we're going to look to

continue those efforts on an education front so that everybody is fully aware what they're assigning and what the ramifications of that are.

We look forward to working with your group, CFO, from the agent standpoint, from the consumer standpoint to make sure that messaging is on point.

CFO PATRONIS: Just on a follow-up note, I'm happy -- there's not a good weather outlook in the Atlantic. I'm looking at a potential -- three different storm systems out here. I guess what I'm worried about is kind of what you were touching on regarding Matthew and Hermine. If a storm were to hit those areas there, how quick or what -- is there an emergency information plan in place that hits the ground?

I know you'll have many carriers in the state that will have boots on the ground. I guess I'm just worried about the exploitation.

COMMISSIONER ALTMAIER: Yes, sir, and it certainly is something to remain concerned of. So, again, very good question.

I can tell you from our experience with Hermine and Matthew, we were very concerned about exactly what you just said, which was an increase

in the number of adjusters that were on the streets trying to convince consumers to sign these benefit forms. So we did have the messaging from that standpoint that went out to as many people as we could get to. We know that the companies were doing the same thing, and we know that the companies -- there's pros and cons with the storms.

The con side is, of course, what you just mentioned, which is you're going to have a lot more claims, and you're going to have companies that are looking to deploy their resources in an effort to get there to the home in front of the contractors.

The pros is that generally speaking, when a storm lands, the companies can tell where they need to be, where the heightened damage is going to be. And we saw that with both Hermine and with Matthew.

Now we did get somewhat fortuitous with Matthew in that it stayed offshore for the most part and really impacted a smaller section of the state than we originally thought. But we heard stories from consumers about getting phone calls in the middle of the night from their insurance

company asking if they were okay, asking if they had damage, asking if they needed to show up and start working on a claim.

And so the good side of this is that the insurance companies realize that that's something that they're going to be faced with, and they are putting in place mechanisms on their side to make sure that when the dust is settled they can get into the communities timely and that they can get to their consumers and they can let their consumers know: We're here to pay your claim and just let us know when you have one.

We heard from a number of consumers that left voicemail messages with our office that said: Never in a million years did I think my insurance company would call me and ask me if I had a claim. And that is -- it's good customer service for the consumer, but the purpose of that is to attempt to get to the home before an adjuster does to execute the assignment of benefits.

And so we will continue to review those communications and make sure that as we prepare for those pending storms, if they should arrive, that we are ready to go with our messaging.

GOVERNOR SCOTT: Anyone else?

(NO RESPONSE).

GOVERNOR SCOTT: I just met with USAA, and they told me that -- this will be off a little bit, but they said they had like 6,000 claims nationwide with regard to windshield damage, and it was something like all but six of them were in Florida.

COMMISSIONER ALTMAIER: Yes, sir.

GOVERNOR SCOTT: What are we doing to deal with that?

COMMISSIONER ALTMAIER: So the windshield issue is actually -- in terms of the volume of assignment of benefits, windshield is actually a lot more -- there's a lot more AOB-related litigation in the windshield space than there is in the property space. So for example, in 2016 we had 28,000 AOB-related lawsuits. About 19,000 of those were windshield related.

And, CFO, to your point, also very localized, but in a different part of the state. They're primarily in the Tampa region.

The good news on the windshield is that the solution we believe to the windshield issue is the same as the solution to the property issue, which is an advantageous attorney-fee framework that encourages these types of lawsuits to be filed

against windshield folks.

So last session, Governor, we had gotten, somewhat late in the process, some language that is very closely aligned with the legislative language that we believe is associated with property, that we think we could run as a package deal that will also address the auto situation.

The only good news with the auto situation is that at this point in time it doesn't seem to be quite as significant a cost driver for the consumer as the property issue does. And so it certainly is an issue that needs to be addressed but not hitting the pocketbooks of consumers quite like the property issue is.

ATTORNEY GENERAL BONDI: Question.

GOVERNOR SCOTT: Attorney General.

ATTORNEY GENERAL BONDI: Why -- personal question. Why do you think it's purely -- mainly in Tampa?

COMMISSIONER ALTMAIER: That's a great question, Attorney General, and I don't know the answer to that question to be perfectly honest with you. And I would anticipate that it will begin to spread. In fact, we are already seeing it spread throughout the state, not nearly to the same volume

as what we're seeing in Tampa.

I was just with some of my colleagues around the country at the NAIC meeting last week, and several other states are coming to me and saying: Don't you guys have an issue with this assignment of benefits? States like Nebraska and other states, and so it is beginning to crop up in other states as well. And so I expect that while it remains kind of a Tampa problem at the moment, I would expect it to begin to spread throughout the state.

ATTORNEY GENERAL BONDI: Okay. Thanks.

GOVERNOR SCOTT: All right. Any other questions?

(NO RESPONSE).

GOVERNOR SCOTT: All right. Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Florida law requires the Governor to independently review legislation and the budget upon passage. Accordingly, I am abstaining from the vote on this item.

If there are no other comments or objections,

the hearing --

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion is approved with one abstention.

Thank you, David.

COMMISSIONER ALTMAIER: Excellent. Thank you all.

GOVERNOR SCOTT: Next I'd like to recognize Drew Breakspear with the Office of Financial Regulation.

ATTORNEY GENERAL BONDI: Governor, could I say one thing real quick? And I feel like a broken record every time -- David, I'm sorry, I feel like a broken record every time you're up here, but my staff, we cannot say enough good things about you and the work you're doing. Thank you.

COMMISSIONER ALTMAIER: Thank you. I appreciate that very much. They're a pleasure to work with, as are all of your staffs. I look forward to continuing to do so.

Thank you.

GOVERNOR SCOTT: Thanks, David.

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Florida Office of Insurance Regulation
Standard Contract

Contract Title: **Professional Services Agreement** Contract Number:

1. This Contract is entered into between the Office of Insurance Regulation and the Contractor named below:

Contractor Information

Contractor Name:	Address:	City, State, Zip:

(hereinafter referred to as "Contractor")

Contract Term

2. Contract Start Date:	Contract End Date:	Renewals:

3. Office's Contract Manager		Contractor's Contract Manager	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	

Terms and Conditions

4. The Office and the Contractor agree to comply with the terms and conditions in the following attachments which are hereby incorporated by reference:

	Attachment 1: Standard Terms and Conditions
	Scope of Services Agreement

5. The Office and the Contractor agree to comply with the terms and conditions of the following addenda which are hereby incorporated by reference:

	Addendum A: Public Records Requirements
	Addendum B: Data Security Requirements

6. Each request for services under this contract shall be in the form of a Scope of Services Agreement. The Scope of Services Agreement shall outline the services requested for the specific matter and shall be submitted in writing to the Contractor.

IN WITNESS WHEREOF, this Contract is being executed by the parties and is effective on the Contract Begin Date above or the last date signed below, whichever is later.

7. **, CONTRACTOR**

Contractor's Name (*if other than individual, state whether corporation, partnership, etc.)*

Date

8. Florida Office of Insurance Regulation **, OFFICE**

Mike Yaworsky, Chief of Staff Date

OFFICE OF INSURANCE REGULATION
Scope of Services Agreement
for
Actuarial consulting Services for Peer Review and Analysis of the Ratemaking Processes of the National Council on Compensation Insurance

1. **Objectives.**
   This service is needed because section 627.285, F.S., requires that the Financial Services Commission ("Commission") contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance in Florida and produce a report by February 1, 2018.

2. **Scope of Work.**
   The scope of work to be performed includes the following:
   Section 627.285, F.S., requires the Commission to contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance. The analysis of ratemaking should specifically include an analysis of the processes employed in evaluating and pricing the effect of legislation or new law. The National Council on Compensation Insurance ("NCCI") is responsible for collecting statistical information and making workers' compensation rate filings on behalf of Florida's insurers. A final report is due to the Commission, President of the Senate, and Speaker of the House by February 1, 2018.

3. **Responsibilities.**
   The tasks to be performed by the awarded Proposer ("Contractor") shall include the following:
   a. Conduct peer review and analysis in accordance with accepted actuarial practice and any standards for such analysis established by the Casualty Actuarial Society ("CAS") and/or the American Academy of Actuaries.
   b. Draft a report which outlines objectives and approach of the project; documents the data used, materials reviewed, assumptions and methodologies employed during the project including reference to any Actuarial Standards of Practice; and details findings and recommendations, if any.
   c. Produce a final report, consistent with format and content described above, to the Office no later than January 3, 2018.
   d. Contractor will attend status meetings which may be conducted by teleconference, as requested by the Office.
   e. Provide expert witness testimony during the 2018 legislative session and/or associated legislative committee weeks as required. Such services will be provided pursuant to a separate contract to be entered into between the Office and the Contractor, in the event such services are required.

4. **Standards and Specifications.**
   All deliverables developed and work conducted by the Contractor pursuant to this Statement of Work ("SOW") shall be performed in accordance with Office's standards and applicable specifications.

5. **Deliverables and Acceptance Criteria.**
The Office will require the Contractor to provide the following:

Deliverable	Deliverable Description and Acceptance Criteria	Consequences for Non-Performance
Peer review and analysis of the ratemaking processes of NCCI in Florida.	Deliverable Description: Produce a report which outlines objectives and approach of the project; documents the data used, materials reviewed, assumptions and methodologies employed during the project, including reference to any Actuarial Standards of Practice; and details findings and recommendations, if any. Performance Standard and Acceptance Criteria: Submit final report to the Office by January 3, 2018, that complies with accepted actuarial practice and any standards for such analysis established by the Casualty Actuarial Society and/or the American Academy of Actuaries.	Failure to complete the required peer review and analysis as outlined in this SOW will result in the rejection of the invoice and will not be paid until correction has been made.
Exit Transition	Provide an Exit Transition Plan, if requested, and otherwise provide all termination or expiration services identified in SOW. Acceptance criteria: Task must be satisfactorily completed within the stated response time after request is made, and must be itemized in invoice.	For non-performance: Failure to complete the required duties as outlined may result in the rejection of the invoice.

6. **Schedule of Deliverables.**
The Contractor agrees to provide the services and deliverables according to the following schedule:

Deliverable	Due Date
Produce a Draft Report	December 13, 2017
Produce a Final Report	January 3, 2018

7. **Acceptance of Work and Performance Standards.**
The Office will use the above standards to determine when each task will be considered acceptable. The Contract Manager may provide additional acceptance criteria during the contract period to be used for the deliverables. Failure to accept a deliverable within twenty (20) days means automatic non-acceptance by the Office unless stated otherwise by the Contract Manager in writing.

8. **Office Duties.**
The Office shall provide any data, if relevant and available, currently in the Office's possession requested by the Contractor needed to complete the report.

9. **Pricing and Invoicing.**
   a. Contractor will be paid in accordance with the terms of this contract, subject to the conditions for the Acceptance Criteria as set forth in this SOW.
   b. This is a fixed price contract.
   c. Total amount billed for the contracted period shall be less than $35,000 dollars.
   d. Rates are effective for work on a 24 X 7 basis.
   e. No travel expenses shall be paid.
   f. Invoices are submitted to:

      Richard Fox
      State of Florida, Office of Insurance Regulation
      200 East Gaines Street, Larson Building, Room 121-J
      Tallahassee, FL 32399
      Richard.Fox@floir.com

10. **Contract Period.**
The contract period for this SOW begins upon execution of a written agreement between the Office and the Contractor and ends close of business on February 28, 2018.

11. **Contract Manager.**
All services will be performed under the direction and control of:

      Cyndi Cooper
      State of Florida, Office of Insurance Regulation
      200 East Gaines Street, Larson Building, Room 212-F
      Tallahassee, FL 32399
      Cyndi.Cooper@floir.com

All written and verbal approvals referenced in this contract must be obtained from the Office's Contract Manager designated in this section or her designees in writing.

OFFICE OF INSURANCE REGULATION

ATTACHMENT 1
STANDARD TERMS AND CONDITIONS

1. **Entire Contract.**
This Contract, including any Attachments and Addenda referred to herein and attached hereto, constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior agreements, whether written or oral, with respect to such subject matter.

2. **Contract Administration.**
   a. Order of Precedence. If there are conflicting provisions between the documents that make up the Contract, the order of precedence for the documents is as follows:
      i) Scope of Services Agreement
      ii) Standard Contract
      iii) Attachments other than the Scope of Services Agreement, in numerical order as designated in the Standard Contract
      iv) The Addenda in alphabetical order as designated in the Standard Contract
   b. All written and verbal approvals referenced in this Contract must be obtained from the parties' Contract Managers as designated in Standard Contract Form or their designees, if designated in writing.
   c. Unless specified otherwise, notices required to be in writing may be delivered or sent to the intended recipient by hand-delivery, certified mail, e-mail, or receipted courier and shall be deemed received on the date received or the date of the certification of receipt.
   d. In the event that different Contract Managers are designated by either party after execution of this Contract, notice of the name and contact information of the new Contract Managers will be submitted in writing to the other party and maintained in the respective parties' Contract records. A change of contract managers does not require a written amendment to the Contract.
   e. This Contract may be amended only by a written agreement between both parties.

3. **Contract Duration.**
   a. Term. The term of the Contract shall begin and end on the dates indicated on the Standard Contract unless terminated earlier in accordance with the applicable terms and conditions.
   b. Renewals. Section 287.058(1)(g), F.S., is hereby incorporated by reference and any renewals provided under the Contract must meet the requirements of this statute. If the Standard Contract indicates renewals are available, the Contract may be renewed for the timeframe(s) indicated in the Standard Contract.

4. **Deliverables.**
The Contractor agrees to render the services as set forth in the Scope of Services Agreement. The services shall be delivered in accordance with the schedule and at the pricing outlined in the Scope of Services Agreement. Deliverables may be comprised of tasks or activities that must be completed prior to the Office making payment on that deliverable.

5. **Performance Measures.**
The Contractor warrants that: (1) the services will be performed by qualified personnel; (2) the services will be of the kind and quality described in the Scope of Services Agreement; (3) the services will be performed in a professional, competent, and efficient manner in accordance with industry standards and practices; (4) the services shall not and do not infringe upon the intellectual property rights, or any other proprietary rights, of any third party; and (5) its employees, agents, or subconsultants shall comply with any security requirements and processes as provided by the Office.

The Office reserves the right to investigate or inspect at any time whether the services or qualifications offered by the Contractor meet the Contract requirements. Notwithstanding any provisions to the contrary, written acceptance of a particular deliverable/minimum requirement does not foreclose the Office's remedies in the event those performance standards that cannot be readily measured at the time of delivery are not met.

6. **Acceptance of Deliverables.**
   a. Acceptance Process. All deliverables must be received and accepted by the Contract Manager before payment or as otherwise provided in the Scope of Services Agreement. The Contractor shall work diligently to correct all deficiencies in the deliverable that remain outstanding, within a reasonable time at the Contractor's expense. If the Contract Manager does not accept the deliverables within 10 days, or as indicated in the Scope of Services, they will be deemed rejected.
   b. Rejection of Deliverables. The Office reserves the right to reject deliverables as outlined in in the Scope of Services Agreement as incomplete, inadequate or unacceptable due in whole or in part to the Contractor's lack of satisfactory performance under the terms of this Contract. The Contractor's efforts to correct the rejected deliverables will be at the Contractor's sole expense. The Contractor shall only invoice the Office for deliverables that are completed in accordance with in the Scope of Services Agreement. Failure to fulfill the applicable technical requirements or complete all tasks or activities in accordance with in the Scope of Services Agreement will result in rejection of the deliverable and the associated invoice. Payment for the rejected deliverable will not be issued unless the rejected deliverable is made acceptable to the Office in accordance with the Contract requirements. The Office, at its option, may allow additional time within which the Contractor may remedy the objections noted by the Office, and the Office may, after having given the Contractor a reasonable opportunity to complete, make adequate or acceptable said deliverables, declare this Contract to be in default.
   c. Status Reports. If status reports are required as part of the Contract, the Contractor shall timely submit status reports attesting to the level of services provided and showing deliverables, tasks or activities worked on, hours spent on each deliverable/task/activity, if applicable, and upcoming major deliverables, tasks or activities.
   d. Completion Criteria and Date. The Contract will be considered complete once all of the deliverables under the Contract have been provided and accepted. The final date for completion of the Contract shall not exceed the Contract duration, including any executed renewals or extensions, or, where applicable, the expiration date of any purchase orders made from the Contract.

7. **Financial Consequences for Nonperformance.**
   Withholding Payment. In addition to the specific consequences explained in the Scope of Services Agreement, the Office reserves the right to withhold payment when the Contractor has failed to perform/comply with provisions of this Contract. These consequences for nonperformance shall not be considered penalties.

8. **Dispute Resolution.**
   Any claim, counterclaim, or dispute between the Office and the Contractor relating to this Contract shall be resolved as set forth herein. For all claims, the party with the dispute shall submit an affidavit executed by that party's Contract Manager or his or her designee certifying that:
      i. The claim is made in good faith,
      ii. The claim accurately reflects the adjustments for performance, and
      iii. The supporting data provided with such an affidavit are current and complete to the Contract Manager's best knowledge and belief.

   The Contractor is obligated to address any cost related issues for which the Contractor believes the Office is liable and address all costs of every type to which the Contractor is entitled from the occurrence of the

claimed event with the Office. The Contractor shall not seek a claim under this Contract for an increase in payment.

a. Informal Resolution Process. If the parties are unable to resolve any disputes after compliance with such processes, the parties shall meet with the Office's Commissioner, or designee, for the purpose of attempting to resolve such dispute without the need for formal legal proceedings, as follows:

   i. The representatives of the Contractor and the Office shall meet as often as the parties reasonably deem necessary in order to gather and furnish to each other all information with respect to the matter at issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives shall discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding.
   ii. During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to this Contract will be honored in order that each of the parties may be fully advised of the other's position.
   iii. The specific format for the discussions will be left to the discretion of the Office and Contractor representatives but may include the preparation of agreed upon statements of fact or written statements of position.
   iv. Following the completion of this process, the Office, or designee, shall issue a written opinion regarding the issue(s) in dispute. The opinion regarding the dispute shall be considered the Office's final action.

b. Continued Performance. Each party agrees to continue performing its obligations under this Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute with the Office over compensation shall not be deemed to preclude performance) and without limiting either party's right to terminate this Contract for convenience or default.

9. Payment.

a. Payment Process. Subject to the terms and conditions established by the Scope of Services Agreement, the pricing per deliverable established by the Price Sheet incorporated into the Scope of Services Agreement, and the billing procedures established by the Office, the Office agrees to pay the Contractor for services rendered in accordance with section 215.422, F.S. To obtain the applicable interest rate, please refer to http://www.myfloridacfo.com/Division/AA/Vendors/default.htm.

b. Vendor Rights. For all purchasing agreements applicable to section 215.422, F.S., a Vendor Ombudsman has been established within the Department. The duties of this individual include acting as an advocate for Contractors who may be experiencing problems in obtaining timely payment(s) from a state agency. The Vendor Ombudsman may be reached at (850) 413-5516.

c. Taxes. The Office is exempted from payment of State sales and use taxes and Federal Excise Tax. The Contractor, however, shall not be exempted from paying State sales and use taxes to the appropriate governmental agencies or for payment by the Contractor to suppliers for taxes on materials used to fulfill its contractual obligations with the Office. The Contractor shall not use the Office's exemption number in securing such materials. The Contractor shall be responsible and liable for the payment of all its FICA/Social Security and other taxes resulting from this Contract. The Contractor shall provide the Office its taxpayer identification number upon request.

d. Invoice Detail. All charges for services rendered or for reimbursement of expenses authorized by the Office pursuant to the Scope of Services Agreement, shall be submitted to the Office in sufficient detail for a proper pre-audit and post-audit to be performed.

e. Annual Appropriation Contingency. Unless otherwise stated in the Contract, the State of Florida's performance and obligation to pay under this contract is contingent upon an annual appropriation by the Legislature.

10. Insurance.

a. Required Coverage. At all times during the Contract, the Contractor and its subcontractors, if any, at its sole expense, shall maintain insurance coverage of such types and with such terms and limits as may be reasonably associated with the Contract. The limits of coverage under each policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. All insurance policies shall be through insurers licensed and authorized to write policies in Florida. Unless specifically exempted in the Scope of Services Agreement, the following are the minimum insurance requirements applicable to this Contract:

i. Commercial General Liability Insurance;
By execution of this Contract, unless the Contractor is a state agency or subdivision as defined by subsection 768.28(2), F.S., the Contractor shall provide adequate commercial general liability insurance coverage and hold such liability insurance at all times during the Contract. A self-insurance program established and operating under the laws of the State may provide such coverage. The Office shall be named as an additional insured on any general liability policies.

ii. Workers' Compensation and Employer's Liability Coverage;
The Contractor shall provide workers' compensation, in accordance with Chapter 440, F.S., and employer's liability insurance with minimum limits of $100,000 per accident, $100,000 per person, and $500,000 policy aggregate. Such policies shall cover all employees engaged in any Contract work.

iii. Other Insurance;
At all times during the Contract, the Contractor shall maintain any other insurance as required in the Scope of Services Agreement.

b. Deductibles. The Office shall be exempt from, and in no way liable for, any sums of money representing a deductible in any insurance policy. The payment of such deductible shall be the sole responsibility of the Contractor providing such insurance.

c. Verification of Insurance. Upon request by the Office, the Contractor shall provide the Office written verification of the existence and amount for each type of applicable insurance coverage or proof of applicable insurance coverage by standard form certificates of insurance.

d. Failure to Maintain Coverage. In the event that any applicable coverage is cancelled by the insurer for any reason, the Contractor shall immediately notify the Office of such cancellation and shall obtain adequate replacement coverage conforming to the requirements herein and provide proof of such replacement coverage within fifteen (15) business days after the cancellation of coverage.

11. Termination.

a. Termination for Convenience. The Office, by written notice to the Contractor, may terminate the Contract in whole or in part, by giving 30 days' written notice, when the Office determines in its sole discretion that it is in the State's interest to do so. The Contractor shall not furnish any service or deliverable after it receives the notice of termination, unless otherwise instructed in the notice. The Contractor shall not be entitled to recover any cancellation charges or lost profits. If the Office determines that the Contractor's words or acts evince an intention to refuse performance in the future, the Office may terminate the Contract.

b. Termination for Cause. The Office may terminate the Contract if any of the Events of Default described below occurs. The Contractor shall continue work on any work not terminated. Except for defaults of subcontractors at any tier, the Contractor shall not be liable for any excess costs if the failure to perform the Contract arises from events completely beyond the control, and without the fault or negligence, of the Contractor. If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is completely beyond the control of both the Contractor and the subcontractor, and without the fault or negligence of either, the Contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted products were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule. If, after termination, it is determined that the Contractor was not in default, or that the default was excusable,

the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Office. The rights and remedies of the Office in this clause are in addition to any other rights and remedies provided by law or under the Contract.

c. Contractor Obligations upon Notice of Termination. After receipt of a notice of termination or partial termination, and except as otherwise directed by the Office, the Contractor shall stop performing services on the date, and to the extent specified, in the notice. The Contractor shall accept no further work or new services related to the affected deliverables, and shall, as soon as practicable, but in no event longer than 30 calendar days after termination, terminate any orders and/or subcontracts related to the terminated deliverables and settle all outstanding liabilities and all claims arising out of such termination of orders and/or subcontracts, with the approval or ratification of the Office to the extent required, which approval or ratification shall be final for the purpose of this section. The Contractor shall not perform any services after it receives the notice of termination or after Contract expiration, except as necessary to complete the transition or continued portion of the Contract, if any. Contractor shall submit to the Office within 90-calendar days of termination a request for payment of completed services. Requests submitted later than 90-calendar days after termination will not be honored and will be returned unpaid. All services for which the Office has paid prior to the termination date of this Contract shall be professionally serviced to conclusion in accordance with the requirements of the Contract. Should the Contractor fail to perform all services under the Contract, the Contractor shall be liable to the Office for any fees or expenses that the Office may incur in securing a substitute provider to assume completion of those services.

d. Contractor Obligations after Termination. If at any time the Contract is canceled, terminated, or expires, and a contract is subsequently executed with a provider other than the Contractor, the Contractor has the affirmative obligation to assist in the smooth transition of Contract services to the subsequent contractor in accordance with Exit Transition requirements in the Scope of Services Agreement.

12. Notice of Default.

If the Contractor defaults in the performance of any covenant or obligation contained in the Contract, including, without limitation, any of the events of default listed below, the Office shall provide notice to the Contractor and an opportunity to cure that is reasonable under the circumstances. This notice shall state the nature of the failure to perform and provide a time certain for correcting the failure. The notice will also provide that, should the Contractor fail to perform within the time provided, the Contractor will be found in default, and the Office may terminate the Contract effective as of the date of receipt of the default notice.

13. Events of Default.

Provided such failure is not the fault of the Office or outside the reasonable control of the Contractor, the following non-exclusive list of events, acts, or omissions, shall constitute events of default:

a. The commitment of any material breach of this Contract by the Contractor, including failure to timely deliver a material deliverable, failure to perform the minimal level of services required for a deliverable, discontinuance of the performance of the work, failure to resume work that has been discontinued within a reasonable time after notice to do so, or abandonment of the Contract;
b. Failure to maintain adequate progress, thus endangering performance of the Contract;
c. Failure to honor any term of the Contract,
d. Failure to abide by any statutory, regulatory, or licensing requirement, including an entry of an order revoking the certificate of authority granted to the Contractor by a state or other licensing authority;
e. Failure to pay any and all entities, individuals, and the like furnishing labor or materials, or failure to make payment to any other entities as required herein in connection with the Contract;
f. Employment of an unauthorized alien in the performance of the work, in violation of section 274 (A) of the Immigration and Nationality Act;

g. One or more of the following circumstances, uncorrected for more than 30-calendar days unless within the specified 30-day period, the Contractor (including its receiver or trustee in bankruptcy) provides to the Office adequate assurances, reasonably acceptable to the Office, of its continuing ability and willingness to fulfill its obligations under the Contract:
   i) Entry of an order for relief under Title 11 of the United States Code;
   ii) The making by the Contractor of a general assignment for the benefit of creditors;
   iii) The appointment of a general receiver or trustee in bankruptcy of the Contractor's business or property;
   iv) An action by the Contractor under any state insolvency or similar law for the purpose of its bankruptcy, reorganization, or liquidation;

h. The commitment of an intentional material misrepresentation or omission in any materials provided to the Office;

i. Failure to comply with the E-Verify requirements of this Contract; and

j. Failure to maintain the insurance required by this Contract.

14. Force Majeure.

The Contractor shall not be responsible for delay resulting from its failure to perform if neither the fault nor the negligence of the Contractor or its employees or agents contributed to the delay and the delay is due directly to acts of God, wars, acts of public enemies, strikes, fires, floods, or other similar cause wholly beyond the Contractor's control, or for any of the foregoing that affect subcontractors or suppliers if no alternate source of supply is available to the Contractor. In case of any delay the Contractor believes is excusable, the Contractor shall notify the Office in writing of the delay or potential delay and describe the cause of the delay either (1) within ten days after the cause that creates or will create the delay first arose, if the Contractor could reasonably foresee that a delay could occur as a result; or (2) if delay is not reasonably foreseeable, within five days after the date the Contractor first had reason to believe that a delay could result. **THE FOREGOING SHALL CONSTITUTE THE CONTRACTOR'S SOLE REMEDY OR EXCUSE WITH RESPECT TO DELAY**. Providing notice in strict accordance with this paragraph is a condition precedent to such remedy. No claim for damages, other than for an extension of time, shall be asserted against the Office. The Contractor shall not be entitled to an increase in the Contract price or payment of any kind from the Office for direct, indirect, consequential, impact or other costs, expenses or damages, including but not limited to costs of acceleration or inefficiency, arising because of delay, disruption, interference, or hindrance from any cause whatsoever. If performance is suspended or delayed, in whole or in part, due to any of the causes described in this paragraph, after the causes have ceased to exist the Contractor shall perform at no increased cost, unless the Office determines, in its sole discretion, that the delay will significantly impair the value of the Contract to the Office, in which case the Office may (1) accept allocated performance or deliveries from the Contractor, provided that the Contractor grants preferential treatment to Office with respect to products subjected to allocation, or (2) purchase from other sources (without recourse to and by the Contractor for the related costs and expenses) to replace all or part of the products that are the subject of the delay, which purchases may be deducted from the Contract quantity, or (3) terminate the Contract in whole or in part.

15. Indemnification.

a. The Contractor shall be fully liable for the actions of its agents, employees, partners, or subcontractors and shall fully indemnify, defend, and hold harmless the Office, and their officers, agents, and employees, from suits, actions, damages, and costs of every name and description arising from or relating to:
   i. personal injury and damage to real or personal tangible property alleged to be caused in whole or in part by Contractor, its agents, employees, partners, or subcontractors; provided, however, that the Contractor shall not indemnify for that portion of any loss or damages proximately caused by the negligent act or omission of the Office;
   ii. the Contractor's breach of this Contract or the negligent acts or omissions of the Contractor;
   iii. violation or infringement of a trademark, copyright, patent, trade secret or intellectual property right; provided, however, that the foregoing obligation shall not apply to an Office misuse or

modification of Contractor's products or operation or use of Contractor's products in a manner not contemplated by the Contract or the purchase order.

b. The Contractor's obligations under the preceding paragraph with respect to any legal action are contingent upon the Office giving the Contractor (1) written notice of any action or threatened action; (2) the opportunity to take over and settle or defend any such action at Contractor's sole expense; and (3) assistance in defending the action at Contractor's sole expense. The Contractor shall not be liable for any cost, expense, or compromise incurred or made by the Office in any legal action without the Contractor's prior written consent, which shall not be unreasonably withheld.

c. If any product is the subject of an infringement suit or in the Contractor's opinion is likely to become the subject of such a suit, the Contractor may at its sole expense procure for the Office the right to continue using the product or to modify it to become noninfringing. If the Contractor is not reasonably able to modify or otherwise secure the Office the right to continue using the product, the Contractor shall remove the product and refund the Office the amounts paid in excess of a reasonable rental for past use. The Office shall not be liable for any royalties.

d. No provision in this Contract shall require the Office to hold harmless or indemnify the Contractor, insure or assume liability for the Contractor's negligence, waive the Office's sovereign immunity under the laws of Florida, or otherwise impose liability on the Office for which it would not otherwise be responsible. Any provision, implication or suggestion to the contrary is null and void.

16. Limitation of Liability.

The Office's liability for any claim arising from this contract is limited to compensatory damages in an amount no greater than the sum of the unpaid balance of compensation due for goods or services rendered pursuant to and in compliance with the terms of the contract. Such liability is further limited to a cap of $100,000.

17. Remedies.

Notwithstanding any provisions to the contrary, written acceptance of a particular deliverable does not foreclose the Office's remedies in the event those performance standards that cannot be readily measured at the time of delivery are not met. Nothing in this Contract shall be construed to make the Contractor liable for force majeure events. Nothing in this Contract, including financial consequences for nonperformance shall limit the Office's right to pursue its remedies for other types of damages under the Contract, at law, or in equity. The Office may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against it. The Office may set off any liability or other obligation of the Contractor or its affiliates to the Office against any payments due the Contractor under any contract with the State.

18. Waiver.

The delay or failure by the Office to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Office's right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

19. Intellectual Property.

The following terms apply, unless otherwise stated in the Scope of Services Agreement:

a. The Contractor's intellectual property rights that preexists this Contract will remain with the Contractor. Intellectual property rights to all property created or otherwise developed by Contractor specifically for the Office will be owned by the Office. Proceeds derived from the sale, licensing, marketing, or other authorization related to any such Office-controlled intellectual property right shall be handled in the manner specified by applicable statute.

b. If the Contractor fails to provide, or no longer can provide, a deliverable or service under the Contract that contains or otherwise utilizes intellectual property controlled by the Contractor, the Contractor

shall grant the Office a royalty-free, paid-up, nonexclusive, perpetual license to use, modify, reproduce, distribute, publish or release to others, such Contractor-controlled intellectual property solely for use in connection with the deliverables or services under the Contract.

20. Ownership of Property.

Title to all property furnished by the Office under this Contract and deliverables provided to the Office shall remain property of the Office and/or become property of the Office upon receipt and acceptance. The Contractor shall perfect any transfer of the property of the Office upon completion, termination, or cancellation of the Contract prior to payment of the final invoice.

21. Nonexclusive Contract.

This Contract is not an exclusive license to provide the services described in the solicitation or the resulting Contract. The Office may, without limitation and without recourse by the Contractor, contract with other vendors to provide the same or similar services.

22. Statutory Notices.

The Office shall consider the employment by any contractor of unauthorized aliens a violation of section 274A(e) of the Immigration and Nationality Act. Pursuant to sections 287.133 and 287.134, F.S., the following restrictions are placed on the ability of persons placed on the convicted vendor list or the discriminatory vendor list:

a. Public Entity Crime. A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in section 287.017, F.S., for CATEGORY TWO for a period of 36 months following the date of being placed on the convicted vendor list.

b. Discriminatory Vendors. An entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity.

The Contractor shall notify the Office if it or any of its suppliers, subcontractors, or consultants have been placed on the convicted vendor list or the discriminatory vendor list during the life of the Contract.

23. Compliance with Federal, State and Local Laws.

a. The Contractor and all its agents shall comply with all federal, state and local regulations, including, but not limited to, nondiscrimination, wages, social security, workers' compensation, licenses, and registration requirements.

b. This Contract shall be governed by and construed in accordance with the laws of the State of Florida.

c. If applicable to the supplies and services the Contractor provides to the Office, the Contractor shall ensure the electronic and information technology accessibility requirements of the Rehabilitation Act Amendments, 29 USC section 794 are met and provide a website where the compliance information on such supplies and services is available. The Electronic and Information Technology standard can be found at: http://www.section508.gov/.

d. Scrutinized Companies. This provision applies only when the goods or services to be provided are $1 million or more. Section 287.135, F.S., requires the Contractor to certify that it is not: 1) on the Scrutinized Companies with Activities in Sudan List, 2) on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or 3) participating in a boycott of Israel. By entering into

this Contract, the Contractor certifies that it is not on either of these lists and that it is not participating in a boycott of Israel. A Contract may be terminated if the Contractor submits a false certification regarding such matters or is placed on either list. In addition, a Contract entered into on or after October 1, 2016, may be terminated if the Contractor is on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel. The State Board of Administration provides a link to the "Scrutinized List of Prohibited Companies" at the following link: https://www.sbafla.com/fsb/FundsWeManage/FRSPensionPlan/PFIA/tabid/1478/ItemId/3351/Default.aspx.

24. Employment Eligibility Verification.

The Contractor is responsible for payment of costs, if any, and retention of records relating to employment eligibility verification. These records are exempt from Chapter 119; F.S. Verification requires the following:

a. The Chief Financial Officer has directed, in cooperation with the Governor's Executive Order 11-116, that the Contractor must participate in the federal E-Verify System for employment eligibility verification under the terms provided in the "Memorandum of Understanding" with the federal Department of Homeland Security if any new employees are hired to work on this Contract during the term of the Contract. The Contractor agrees to provide to the Office, within 30 days of hiring new employees to work on this Contract, documentation of such enrollment in the form of a copy of the E-Verify "Edit Company Profile" screen, which contains proof of enrollment in the E-Verify System. Information on "E-Verify" is available at the following website: www.dhs.gov/e-verify.

b. The Contractor further agrees that it will require each subcontractor that performs work under this Contract to enroll and participate in the E-Verify System if the subcontractor hires new employees during the term of this Contract. The Contractor shall include this provision in any subcontract and obtain from the subcontractor(s) a copy of the "Edit Company Profile" screen indicating enrollment in the E-Verify System and make such record(s) available to the Office upon request.

c. In the event legislation authorizes an alternative option as proof of legal status, the Contractor may use the process authorized by such legislation upon its passage.

25. Storage of State Data.

All data centers used to process and store State Data under this Contract shall only be located in the United States.

26. Applicable Law and Disputes.

Any dispute concerning performance of the Contract shall be processed according to the Scope of Services Agreement. Jurisdiction for any damages arising under the terms of the Contract will be in the courts of the State of Florida, and venue will be in the Second Judicial Circuit, in and for Leon County. Except as otherwise provided by law, the parties agree to be responsible for their own attorney fees incurred in connection with disputes arising under the terms of this Contract.

27. Lobbying and Integrity.

The Contractor agrees that no funds received by it under this Contract will be expended for the purpose of lobbying the Legislature or a State agency pursuant to section 216.347, F.S., except that pursuant to the requirements of section 287.058(6), F.S., during the term of any executed contract between the Contractor and the State, the Contractor may lobby the executive or legislative branch concerning the scope of services, performance, term, or compensation regarding that contract.

The Contractor shall comply with sections 11.062 and 216.347, F.S. The Contractor shall not, in connection with this or any other agreement with the State, directly or indirectly (1) offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for any State officer or employee's decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty; or (2) offer, give, or agree to give to anyone any gratuity for the benefit of, or at the direction or request of, any State officer or employee. For purposes of clause (2), "gratuity" means any payment of more than nominal

monetary value in the form of cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. Upon request of the Office's Inspector General, or other authorized State official, the Contractor shall provide any type of information the Inspector General deems relevant to the Contractor's integrity or responsibility. Such information may include, but shall not be limited to, the Contractor's business or financial records, documents, or files of any type or form that refer to or relate to the Contract. The Contractor shall retain such records for the longer of (1) three years after the expiration of the Contract or (2) the period required by the General Records Schedules maintained by the Florida Department of State (available at: http://dos.myflorida.com/library-archives/records-management/general-records-schedules/). The Contractor agrees to reimburse the State for the reasonable costs of investigation incurred by the Inspector General or other authorized State official for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the State which results in the suspension or debarment of the Contractor. Such costs shall include, but shall not be limited to: salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor shall not be responsible for any costs of investigations that do not result in the Contractor's suspension or debarment.

28. **Independent Contractor.**
The Contractor is an independent contractor and is not an employee or agent of the Office.

29. **Subcontracting.**
Unless otherwise specified in the Scope of Services Agreement, all services contracted for are to be performed solely by the Contractor and may not be subcontracted or assigned without the prior written consent of the Office.

30. **Guarantee of Parent Company.**
In the event the Contractor is a subsidiary of another corporation or other business entity, the Contractor asserts that its parent company will guarantee all of the obligations of the Contractor for purposes of fulfilling the obligations of the Contract. In the event the Contractor is sold during the period the Contract is in effect, the Contractor agrees that it will be a requirement of sale that the new parent company guarantee all of the obligations of the Contractor.

31. **Survival.**
The respective obligations of the parties, which by their nature would continue beyond the termination or expiration of this Contract, including without limitation, the obligations regarding confidentiality, proprietary interests, and public records, shall survive termination, cancellation or expiration of this Contract.

32. **Exit Transition Services.**
The Contractor shall provide transition services (Exit Transition Services) to the Office without regard to the reason for termination, as stated herein. Exit Transition Services shall be provided for up to the period outlined in the Scope of Services Agreement during the term and after termination and will be limited to post-contract activities involving knowledge transfer for such services and deliverables and all reasonable termination assistance requested by the Office to facilitate the orderly transfer of such services to the Office or its designees.

33. **Third Parties.**
The Office shall not be deemed to assume any liability for the acts, omissions to act or negligence of the Contractor, its agents, servants, and employees, nor shall the Contractor disclaim its own negligence to the Office or any third party. This Contract does not and is not intended to confer any rights or remedies upon any person other than the parties. If the Office consents to a subcontract, the Contractor will specifically

disclose that this Contract does not create any third party rights. Further, no third parties shall rely upon any of the rights and obligations created under this Contract.

34. Severability.
If a court of competent jurisdiction deems any term or condition herein void or unenforceable, the other provisions are severable to that void provision, and shall remain in full force and effect.

35. Employment of State Employees.
During the term of this Contract, the Contractor shall not knowingly employ, subcontract with or subgrant to any person (including any nongovernmental entity in which such person has any employment or other material interest as defined in section 112.312(15), F.S.), who is employed by the State or who has participated in the performance or procurement of this Contract except as provided in section 112.3185, F.S.

36. Contractor's Employees, Subcontractors and Agents.

a. All Contractor employees, subcontractors, or agents performing work under the Contract shall be properly trained technicians who meet or exceed any specified training qualifications. Upon request, Contractor shall furnish a copy of technical certification or other proof of qualification.
b. All employees, subcontractors, or agents performing work under the Contract must comply with all security and administrative requirements of the Office and shall comply with all controlling laws and regulations relevant to the services they are providing under the Contract. The State may conduct, and the Contractor shall cooperate in, a security background checks or otherwise assess any employee, subcontractor, or agent furnished by the Contractor.
c. The Office may refuse access to, or require replacement of, any personnel for cause, including, but not limited to, technical or training qualifications, quality of work, change in security status, or noncompliance with the Office's security or other requirements. Such refusal shall not relieve the Contractor of its obligation to perform all work in compliance with the Contract.
d. The Office may reject and deny access to the Office's secure information or any facility for cause by any of the Contractor's employees, subcontractors, or agents.
e. The Office will not deny the Contractor's employees, subcontractors, or agents access to meetings within the Office's facilities, unless the basis of the Office's denial is safety or security considerations.
f. The Contractor is as responsible for the performance of the subcontractors as it would be if it had rendered these services itself.
g. The Contractor is solely responsible for payment of any subcontractors.

37. Suspension of Work.
The Office may in its sole discretion suspend any or all activities under the Contract, at any time, when it is in the best interests of the state to do so. The Office shall provide the Contractor written notice outlining the particulars of suspension. Examples of reasons for suspension include, but are not limited to, budgetary constraints, declaration of emergency, or other such circumstances. After receiving a suspension notice, the Contractor shall comply with the notice. Within 90 days, or any longer period agreed to by the Contractor, the Office shall either (1) issue a notice authorizing resumption of work, at which time activity shall resume; or (2) terminate the Contract. Suspension of work shall not entitle the Contractor to any additional compensation.

38. Advertising.
Subject to Chapter 119, F.S., the Contractor shall not publicly disseminate any information concerning the Contract without prior written approval from the Office, including, but not limited to, mentioning the Contract in a press release or other promotional material, identifying the Office or the state as a reference or otherwise linking the Contractor's name and either a description of the Contract or name of the State or the Office in any material published, either in print or electronically, to any entity that is not a party to the Contract, except potential or actual authorized distributor, dealers, resellers, or service representatives.

39. **Assignment.**
The Contractor shall not sell, assign or transfer any of its rights, duties or obligations under the Contract, or under any purchase order issued pursuant to the Contract, without the prior written consent of the Office. In the event of any assignment, the Contractor remains secondarily liable for performance of the Contract, unless the Office expressly waives such secondary liability. The Office may assign the Contract with prior written notice to the Contractor of its intent to do so.

40. **Audits.**
The Contractor understands its duty, pursuant to section 20.055(5), F.S., to cooperate with the Inspector General in any investigation, audit, inspection, review, or hearing. The Contractor will comply with this duty and ensure that its Subcontracts issued under this Contract, if any, impose this requirement, in writing, on its subcontractors.

41. **Execution in Counterparts and Authority to Sign.**
This Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute the same instrument. Each person signing this Contract warrants that he or she is duly authorized to do so and to bind the respective party to the Contract.

42. **Travel Reimbursement.**
Any travel expenses allowable under this Contract must be submitted in accordance with section 112.061, F.S.

43. **MyFloridaMarketPlace Transaction Fee.**
The State has instituted MyFloridaMarketPlace, a statewide eProcurement System. Pursuant to section 287.057(22), F.S., all payments shall be assessed a Transaction Fee, which the Contractor shall pay to the State, unless exempt pursuant to Rule 60A-1.032, F.A.C. For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the Contractor. If automatic deduction is not possible, the Contractor shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), F.A.C. By submission of these reports and corresponding payments, Contractor certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee. Contractor shall receive a credit for any Transaction Fee paid by the Contractor for the purchase of any item(s) if such item(s) are returned to the Contractor through no fault, act, or omission of the Contractor. Notwithstanding the foregoing, a Transaction Fee is nonrefundable when an item is rejected or returned, or declined, due to the Contractor's failure to perform or comply with specifications or requirements of the agreement. Failure to comply with these requirements shall constitute grounds for declaring the Contractor in default and recovering procurement costs from the Contractor in addition to all outstanding fees. Contractors delinquent in paying transaction fees may be subject to being removed from the Department of Management Services' vendor list as provided in Rule 60A-1.006, F.A.C.

44. **Use of State Funds to Purchase or Improve Real Property.**
Any State funds provided for the purchase of or improvements to real property are contingent upon the Contractor granting to the State a security interest in the property in the amount of State funds provided for five years from the date of purchase or the completion of the improvements or as further required by law.

Office of Insurance Regulation

Public Records Requirements

Addendum A

1. **Public Records Access Requirements.**

a. If the Contractor is acting on behalf of the Office in its performance of services under the Contract, the Contractor must allow public access to all documents, papers, letters, or other material, regardless of the physical form, characteristics, or means of transmission, made or received by the Contractor in conjunction with the Contract (Public Records), unless the Public Records are exempt from public access pursuant to section 24(a) of Article I of the Florida Constitution or section 119.07(1), F.S.

b. The Office may unilaterally terminate the Contract if the Contractor refuses to allow public access to Public Records as required by law.

2. **Public Records Requirements Applicable to All Contractors.**

a. For purposes of the Contract, the Contractor is responsible for becoming familiar with Florida's Public Records law, consisting of Chapter 119, F.S., section 24(a) of Article I of the Florida Constitution, or other applicable state or federal law (Public Records Law).

b. All requests to inspect or copy Public Records relating to the Contract must be made directly to the Office. Notwithstanding any provisions to the contrary, disclosure of any records made or received by the State in conjunction with the Contract is governed by Public Records Law.

c. If the Contractor has a reasonable, legal basis to assert that any portion of any records submitted to the Office are confidential, proprietary, trade secret, or otherwise not subject to disclosure ("Confidential" or "Trade Secret") under Public Records Law or other authority, the Contractor must simultaneously provide the Office with a separate redacted copy of the records the Contractor claims as Confidential or Trade Secret and briefly describe in writing the grounds for claiming exemption from the Public Records Law, including the specific statutory citation for such exemption. The un-redacted copy of the records shall contain the Contract name and number, and shall be clearly labeled "Confidential" or "Trade Secret." The redacted copy of the records should only redact those portions of the records that the Contractor claims are Confidential or Trade Secret. If the Contractor fails to submit a redacted copy of records it claims are Confidential or Trade Secret, such action may constitute a waiver of any claim of confidentiality.

d. If the Office receives a Public Records request, and if records that have been marked as "Confidential" or "Trade Secret" are responsive to such request, the Office shall provide the Contractor-redacted copies to the requester. If a requester asserts a right to the portions of records claimed as Confidential or Trade Secret, the Office shall notify the Contractor that such an assertion has been made. It is the Contractor's responsibility to assert that the portions of records in question are exempt from disclosure under Public Records Law or other authority. If the Office becomes subject to a demand for discovery or disclosure of the portions of records the Contractor claims as Confidential or Trade Secret in a legal proceeding, the Office shall give the Contractor prompt notice of the demand, when possible, prior to releasing the portions of records the Contractor claims as Confidential or Trade Secret (unless disclosure is otherwise prohibited by applicable law). The Contractor shall be responsible for defending its determination that the redacted portions of its records are Confidential or Trade Secret. No right or remedy for damages against the Office arises from any disclosure made by the Office based on the Contractor's failure to promptly legally protect its claim of exemption and commence such protective actions within ten days of receipt of such notice from the Office.

e. If the Contractor claims that the records are "Trade Secret" pursuant to section 624.4213, F.S., and all the requirements of section 624.4213(1), F.S., are met, the Office will respond to the Public Records Request in accordance with the provisions specified in that statute.

f. The Contractor shall ensure that exempt or confidential and exempt Public Records are not disclosed except as permitted by the Contract or by Public Records Law.

3. Additional Public Records Duties of Section 119.0701, F.S., If Applicable.

If the Contractor is a "contractor" as defined in section 119.0701(1)(a), F.S., the Contractor shall:

(1) Keep and maintain Public Records required by the Office to perform the service.

(2) Upon request, provide the Office with a copy of requested Public Records or allow the Public Records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, F.S., or as otherwise provided by law.

(3) A Contractor who fails to provide the Public Records to the Office within a reasonable time may be subject to penalties under section 119.10, F.S.

(4) Ensure that Public Records that are exempt or confidential and exempt from Public Records disclosure requirements are not disclosed except as authorized by law for the duration of the Contract term and following completion of the Contract if the Contractor does not transfer the Public Records to the Office.

(5) Upon completion of the Contract, transfer, at no cost, to the Office all Public Records in possession of the Contractor or keep and maintain Public Records required by the Office to perform the service. If the Contractor transfers all Public Records to the Office upon completion of the Contract, the Contractor shall destroy any duplicate Public Records that are exempt or confidential and exempt from Public Records disclosure requirements. If the Contractor keeps and maintains Public Records upon completion of the Contract, the Contractor shall meet all applicable requirements for retaining Public Records. All Public Records stored electronically must be provided to the Office, upon request from the Office's custodian of Public Records, in a format specified by the Office as compatible with the information technology systems of the Office. These formatting requirements are satisfied by using the data formats as authorized in the Contract or Microsoft Word, Outlook, Adobe, or Excel, and any software formats the Contractor is authorized to access.

(6) **IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, F.S., TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THE CONTRACT, CONTACT PUBLIC RECORDS AT:**

Telephone: (850) 413-4223
Email: PublicRecords@floir.com
Mailing Address: The Office of Insurance Regulation
200 E. Gaines Street
Tallahassee, Florida 32399-4206

DEPARTMENT OF FINANCIAL SERVICES

Data Security Requirements

Addendum B

1. **Data Security.**
The Contractor, its employees, subcontractors, and agents, shall comply with Rule Chapter 74-2, Florida Administrative Code (F.A.C.), which contains information technology (IT) security procedures and requires adherence to the Department's security policies, the relevant parts of which are contained herein, in performance of this Contract. The Contractor shall provide immediate notice to the Department's Information Security Office, within the Office of Information Technology, in the event it becomes aware of any security breach or any unauthorized transmission or loss of any or all of the data collected, created for, or provided by the Department (State Data). Except as required by law or legal process, and after notice to the Department, the Contractor shall not divulge to third parties any Confidential Information obtained by the Contractor or its agents, distributors, resellers, subcontractors, officers, or employees in the course of performing Contract work according to applicable rules, including, but not limited to, Rule Chapter 74-2, F.A.C. "Confidential Information" means information in the possession of, or under the control of, the state of Florida (State) or the Contractor that is exempt from public disclosure pursuant to Chapter 119, Florida Statutes (F.S.), or to any other applicable provision of State or federal law that serves to exempt information from public disclosure. This includes, but is not limited to, the security procedures, business operations information, or commercial proprietary information in the possession of the State or the Department. The Contractor will not be required to keep confidential any information that is publicly available through no fault of the Contractor, material that the Contractor developed independently without relying on the State's Confidential Information, or information that is otherwise obtainable under State law as a public record.

2. **Data Protection.**
No State Data will be transmitted, processed, or stored outside of the United States of America regardless of method, except as required by law. Access to State Data will only be available to staff approved and authorized by the Department that have a legitimate business need. Access to State Data does not include remote support sessions for devices that might contain the State Data; however, during remote support sessions the Department requires the Contractor to escort the remote support access and maintain visibility of the support personnel's actions. The Contractor shall encrypt all data transmissions containing Confidential Information. The Contractor agrees to protect, indemnify, defend, and hold harmless the Department from and against any and all costs, claims, demands, damages, losses, and liabilities arising from or in any way related to the Contractor's breach of this addendum or the negligent acts or omissions of the Contractor related to this addendum.

3. **Separate Security Requirements.**
Any Criminal Justice Information Services-specific and/or Health Information Portability and Accountability Act-specific security requirements are attached in a separate addendum, if applicable. The Contractor shall develop data security procedures to ensure only authorized access to data submissions by personnel for contracted activities.

4. **Ownership of State Data.**
State Data will be made available to the Department upon its request, in the form and format reasonably requested by the Department. Title to all State Data will remain property of the Department and/or become property of the Department upon receipt and acceptance. The Contractor shall not possess or assert any lien or other right against or to any State Data in any circumstances.

M E M O R A N D U M

DATE: September 28, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Stephen Fredrickson, Assistant General Counsel

SUBJECT: Cabinet Agenda for October 17, 2017
Request for Final Approval to Adopt Repeal of
Rules 69O-154.110,.111
Assignment # 207474-17

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before October 11, 2017, and to the Financial Services Commission on October 17, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on September 29, 2017.

The notice of proposed rules was published on August 21, 2017, in Volume 43, No. 162, of the *Register*. The hearing was not requested; therefore, the hearing was not held.

Rules 69O-154.110 and .111 provided guidelines for issuance of certificates of creditable coverage. Due to a change in statute, a certificate of creditable coverage is no longer required. Therefore, the rules are no longer necessary.

Sections 624.308; 627.6561(5)(b), (7)(b),(8)(a)(e), (9)(b); 641.31071; 624.307(1); 627.64871; 627.6561(8), F.S., are the rulemaking authority and laws implemented for these rules.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee and confirmed that their review of the rules has been completed.

Stephen Fredrickson is the attorney handling these rules. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

69O-154.110 Certificate of Creditable Coverage.

Rulemaking Authority 624.308, 627.6561(8)(e), 641.31071(8)(a), (e), (10)(b) FS. Law Implemented 624.307(1), 627.64871, 627.6561(8), 641.31071 FS. History–New 9-19-00, Formerly 4-154.110, Repealed_____.

69O-154.111 Demonstration of Creditable Coverage If Certificate is not Provided.

Rulemaking Authority 624.308, 627.6561(5)(b), (7)(b), (8)(a), (e), (9)(b), 641.31071(8)(a), (e), (10)(b) FS. Law Implemented 624.307(1), 627.64871, 641.31071 FS. History–New 9-19-00, Formerly 4-154.111, Repealed_____.

~~**69O-154.110 Certificate of Creditable Coverage.**~~

~~(1) A health insurance issuer in the individual market shall provide a certificate of creditable coverage and make other disclosures regarding an individual's coverage under an individual policy necessary to enable individuals to avoid or reduce pre-existing condition exclusions included under subsequent group health insurance coverage the individual may obtain.~~

~~(2) Issuers shall establish procedures by which individuals and dependents shall request and receive certificates.~~

~~(3) The certificate shall read as indicated on Form OIR-1361 (rev. 10/98), Certificate of Individual Health Coverage, which is hereby adopted and incorporated by reference, and may be obtained from the Bureau of Life and Health Forms & Rates, 200 East Gaines Street, Tallahassee, Florida 32399-0328.~~

~~(4)(a) Individuals have the right to receive a certificate automatically, without charge, when they lose coverage under an individual policy.~~

~~(b) A certificate shall also be provided upon a request by, or on behalf of, an individual no later that 24 months after coverage ceases even if a certificate has previously been provided when coverage was originally lost.~~

~~(c) The certificate shall be provided at the earliest time that an issuer, acting in a reasonable and prompt fashion, can provide the certificate.~~

~~(5)(a) An issuer of an individual policy shall prepare certificates with respect to the coverage on any of the individual's dependents that are covered under the individual policy.~~

~~(b) Until July 1, 1998, an issuer may satisfy the obligation to provide a written certificate regarding coverage of a dependent of a policyholder by providing the name of the policyholder covered by the policy and specifying the type of coverage as family coverage.~~

~~(c) If requested to provide a certificate related to a dependent, the issuer shall make a reasonable effort to obtain and provide the name of the dependent.~~

~~(6)(a) The certificate shall be provided, without charge, to each individual or an entity requesting the certificate on behalf of the individual.~~

~~(b) The certificate may be provided by first-class mail.~~

~~(c) If the certificate or certificates are provided to the individual and the individual's spouse at the individual's last known address, the requirements of this section are satisfied with respect to all individuals and dependents residing at that address.~~

~~(d) If a dependent does not reside at the individual's last known address, a separate certificate shall be provided to the dependent at the dependent's last known address.~~

~~(e) If separate certificates are provided by mail to individuals and dependents who reside at the same address, separate mailings of each certificate are not required.~~

~~(7)(a) If an automatic certificate must be provided, and the individual or dependent entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificate may provide the certificate to the designed party.~~

~~(b) If the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificates shall provide the certificate to the designated party.~~

~~(8)(a) If an individual enrolls in a group health plan and the plan or issuer uses the alternative method of determining creditable coverage for categories of benefits as authorized in Section 627.6561(7)(b), F.S., the prior entity shall, upon request of the assuming entity, promptly furnish the categories of benefits and services used by the individual for which the requesting entity uses the alternative method of crediting coverage, and any specific information that the requesting entity requests to determine the individual's creditable coverage.~~

~~(b) Nothing in the Insurance Code is interpreted to prohibit the prior entity furnishing this information from charging the requesting entity for the reasonable cost of disclosing the information.~~

~~*Rulemaking Authority 624.308, 627.6561(8)(c), 641.31071(8)(a), (c), (10)(b) FS. Law Implemented 624.307(1), 627.64871, 627.6561(8), 641.31071 FS. History New 9-19-00, Formerly 4-154.110.*~~

69O-154.111 Demonstration of Creditable Coverage If Certificate is not Provided.

(1) Individuals may establish creditable coverage through means other than certificates. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage and waiting periods through the presentation of documents or other means.

(2)(a) An issuer shall take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether or not an individual has 18 months of creditable coverage.

(b) An issuer shall treat the individual as having furnished a certificate if the individual:

1. Attests to the period of creditable coverage;

2. Presents relevant corroborating evidence of some creditable coverage during the period; and,

3. Cooperates with the issuer's efforts to verify the individual's coverage.

(3)(a) For this purpose, cooperation includes:

1. Providing, upon the issuer's request, written authorization for the issuer to request a certificate on behalf of the individual; and,

2. Cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage.

(b) An issuer may refuse to credit coverage if the individual fails to cooperate with the issuer's efforts to verify coverage; however, the issuer shall not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(4) Documents that shall be accepted as evidence to establish creditable coverage and waiting periods in the absence of a certificate include:

(a) Explanations of benefit (EOB) claims or other correspondence from a plan or issuer indicating coverage;

(b) Pay stubs showing a payroll deduction for health coverage;

(c) A health insurance identification card;

(d) A certificate of coverage under a group health policy;

(e) Records from medical care providers indicating health coverage;

(f) Third party statements verifying periods of coverage; and,

(g) Any other relevant documents that evidence periods of health coverage.

(5) Means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage, shall be accepted as evidence of creditable coverage or waiting period information if the means indicate information about satisfaction of a waiting period or the existence of creditable coverage.

(6) If, in the course of providing evidence including a certificate of creditable coverage, an individual shall demonstrate dependent status, the issuer shall treat the individual as having furnished a certificate showing the dependent status if the individual:

(a) Attests to the dependency and the period of the status; and,

(b) Cooperates with the issuer's efforts to verify the dependent status.

Rulemaking Authority 624.308, 627.6561(5)(b), (7)(b), (8)(a), (e), (9)(b), 641.31071(8)(a), (e), (10)(b) FS. Law Implemented 624.307(1), 627.64871, 641.31071 FS. History–New 9-19-00, Formerly 4-154.111.

69O-154.110,.111 Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

627.6561 Preexisting conditions.—
(1) As used in this section, the term:
(a) "Enrollment date" means, with respect to an individual covered under a group health policy, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.
(b) "Late enrollee" means, with respect to coverage under a group health policy, a participant or beneficiary who enrolls under the policy other than during:
1. The first period in which the individual is eligible to enroll under the policy.
2. A special enrollment period, as provided under s. 627.65615.
(c) "Waiting period" means, with respect to a group health policy and an individual who is a potential participant or beneficiary of the policy, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the policy.
(2) Subject to the exceptions specified in subsection (4), an insurer that offers group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:
(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;
(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and
(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3), applicable to the participant or beneficiary as of the enrollment date.
(3) Genetic information may not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.
(4)(a) Subject to paragraph (b), an insurer that offers group health insurance coverage may not impose any preexisting condition exclusion in the case of:
1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.
2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision does not apply to coverage before the date of such adoption or placement for adoption.
3. Pregnancy.
(b) [1]Subparagraphs 1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

641.31071 Preexisting conditions.—
(1) As used in this section, the term:
(a) "Enrollment date" means, with respect to an individual covered under a group health maintenance organization contract, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.
(b) "Late enrollee" means, with respect to coverage under a group health maintenance organization contract, a participant or beneficiary who enrolls under the contract other than during:
1. The first period in which the individual is eligible to enroll under the plan.
2. A special enrollment period, as provided under s. 641.31072.
(c) "Waiting period" means, with respect to a group health maintenance organization contract and an individual who is a potential participant or beneficiary under the contract, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the contract.
(2) Subject to the exceptions specified in subsection (4), a health maintenance organization that offers group coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:
(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;
(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and
(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3), applicable to the participant or beneficiary as of the enrollment date.
(3) Genetic information shall not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.
(4)(a) Subject to paragraph (b), a health maintenance organization that offers group coverage may not impose any preexisting condition exclusion in the case of:
1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.
2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of such adoption or placement for adoption.
3. Pregnancy.
(b) Subparagraphs (a)1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

69O-149.204 Outline of Coverage.

Rulemaking Authority 624.308, 627.6675(3)(c) FS. Law Implemented 624.307(1), 627.6498(4), 627.6675(3), 641.3922(3) FS. History–New 3-2-00, Amended 4-2-01, 4-17-02, Formerly 4-149.204, Amended 5-18-04 Repealed_____.

69O-149.204 Outline of Coverage.

(1) This section provides an outline of the benefits considered in determining the standard risk rates.

(2) The reference to the 2003 Standard Health Benefit Plan refers to the plan recommended by the health benefit committee pursuant to Section 627.6699(12), F.S., and approved by the Office of Insurance Regulation. These plan designs can be found by accessing: http://www.floir.com/Sections/LandH/ProductReview/is_LHFR_Small_Emp_Benefit_Plan.aspx.

(3) It is noted that this list is an outline of the Standard Health Benefit Plans pursuant to Sections 627.6675(11) and 641.3922(10), F.S., and is not intended to be a comprehensive description of all policy benefits. The statutory sections indicated should be reviewed for more comprehensive information.

	Plan A	Plan B	Plan C
PPO/EPO and Indemnity	Standard Health Benefit Plan	2003 Standard Health Benefit Plan	2003 Standard Health Benefit Plan
Lifetime Limit	$1,000,000	$5,000,000	$5,000,000
Annual Deductible* Single/Family	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000
Out-of-Pocket Maximum Single/Family	$2,000/$4,000	$3,000/$6,000	$5,000/$10,000
Plan Coinsurance Amount: (1) Preferred Provider (2) Indemnity Plan	 (1) 80% of allowance in-network/60% of allowance out-of-network. (2) 80% of allowance.	 (1) 80% of allowance in-network/60% of allowance out-of-network. (2) 80% of allowance.	 (1) 80% of allowance in-network/60% of allowance out-of-network. (2) 80% of allowance.
Physician	Coinsurance	Coinsurance	Coinsurance
Specialist	Coinsurance	Coinsurance	Coinsurance
Maternity	Coinsurance	Coinsurance	Coinsurance
Prescription Drug	$7/$14 Copay	$10/$30/$50 Copay*	$10/$30/$50 Copay*
In-Patient Hospital	Coinsurance	Coinsurance	Coinsurance
Out-Patient Hospital	Coinsurance	Coinsurance	Coinsurance
Out-Patient Rehabilitation	Coinsurance, 10 visits per year	Coinsurance, 20 visits per year	Coinsurance, 20 visits per year
Emergency	Coinsurance +$50 Copay per visit	Coinsurance	Coinsurance
Mental and Nervous Disorders, In-Patient	Coinsurance, 10 days per year	Coinsurance, 10 days per year	Coinsurance, 10 days per year
Mental and Nervous Disorders, Out-Patient	Coinsurance, 20 visits per year, $50 per visit maximum reimbursement	Coinsurance, 20 visits per year, $50 per visit maximum reimbursement	Coinsurance, 20 visits per year, $50 per visit maximum reimbursement
Alcohol/Substance Abuse, In-Patient	Not covered	Coinsurance, $2,000 maximum benefit	Coinsurance, $2,000 maximum benefit
Alcohol/Substance Abuse, Out-Patient	Not covered	Coinsurance, $2,000 maximum benefit	Coinsurance, $2,000 maximum benefit
Preventive Medical Services	Coinsurance, $150 maximum per year	Coinsurance, $250 maximum per year	Coinsurance, $250 maximum per year
Organ Transplant	$200,000 lifetime maximum	Coinsurance	Coinsurance
Home Health Care	Coinsurance, 60 visits per year, maximum $60 per visit	Coinsurance, 60 visits per year	Coinsurance, 60 visits per year

	Plan A	Plan B HMO plan	Plan C HMO plan

HMO	Standard Health Benefit Plan	2003 Standard Health Benefit Plan	2003 Standard Health Benefit Plan
Lifetime Limit	None	$5,000,000	$5,000,000
Out-of-Pocket Maximum Single/Family	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000
Primary Care Physician	$10 Copay per visit	$25 Copay per visit	$25 Copay per visit
Specialist	$10 Copay per visit	$50 Copay per visit	$50 Copay per visit
Maternity	Covered	$300 Copay per day for five days	$300 Copay per day for five days
Prescription Drug	$7/$14 Copay	$10/$30/$50 Copay*	$10/$30/$50 Copay*
In-Patient Hospital	$100 Copay per day	$300 Copay per day for five days	$300 Copay per day for five days
Out-Patient Hospital	$50 Copay per procedure	$200 Copay per procedure	$200 Copay per procedure
Out-Patient Rehabilitation	$20 Copay per visit, 10 visits per year	$25 Copay per visit, 20 visits per year	$25 Copay per visit, 20 visits per year
Out-of-Network (emergency only)	Covered	Covered	Covered
Emergency	$100 Copay (if not admitted)	$150 Copay (if not admitted)	$150 Copay (if not admitted)
Mental and Nervous Disorders, In-Patient	$100 Copay per day for first 5 days, 10 days per year	$100 Copay per day, 10 days per year	$100 Copay per day, 10 days per year
Mental and Nervous Disorders, Out-Patient	$10 Copay per visit, 20 visits per year, $50 per visit maximum reimbursement	$25 Copay per visit, 20 visits per year, $50 per visit maximum reimbursement	$25 Copay per visit, 20 visits per year, $50 per visit maximu reimbursement
Alcohol/Substance Abuse, In-Patient	Not covered	$100 Copay per day, $2,000 maximum benefit	$100 Copay per day, $2,000 maximum benefit
Alcohol/Substance Abuse, Out-Patient	Not covered	$25 Copay per visit, $2,000 maximum benefit	$25 Copay per visit, $2,000 maximum benefit
Preventive Medical Services	$150 maximum	$250 maximum	$250 maximum
Organ Transplant	$200,000 lifetime maximum	Covered	Covered
Home Health Care	Covered in full, 60 visits per year	$25 Copay per visit, 60 visits per year	$25 Copay per visit, 60 visits per year

*Not included in out of pocket maximum

	Plan A	Plan D coins plan	Plan E- coins plan
HMO	Standard Health Benefit Plan	2003 Standard Health Benefit Plan	2003 Standard Health Benefit Plan
Lifetime Limit	None	$5,000,000	$5,000,000
Annual Deductible* Single/Family	Not applicable	$1,000/$3,000	$1,000/$3,000
Out-of-Pocket Maximum Single/Family	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000
Plan Coinsurance Amount:	Not applicable	80% of allowance	80% of allowance
Primary Care Physician	$10 Copay per visit	Coinsurance	Coinsurance
Specialist	$10 Copay per visit	Coinsurance	Coinsurance
Maternity	Covered	Coinsurance	Coinsurance
Prescription Drug	$7/$14 Copay	$10/$30/$50 Copay*	$10/$30/$50 Copay*
In-Patient Hospital	$100 Copay	Coinsurance	Coinsurance
Out-Patient Hospital	Covered	Coinsurance	Coinsurance
Out-of-Network (emergency only)	Covered	Coinsurance	Coinsurance

Emergency	$100 Copay (if not admitted)	Coinsurance	Coinsurance
Mental and Nervous Disorders, In-Patient	$100 Copay per day for first 5 days, 10 days per year	Coinsurance, 10 days per year	Coinsurance, 10 days per year
Mental and Nervous Disorders, Out-Patient	$10 Copay per visit, 20 visits per year, $50 per visit maximum reimbursement	Coinsurance, 20 visits per year, $50 per visit maximum reimbursement	Coinsurance, 20 visits per year $50 per visit maximum reimbursement
Alcohol/Substance Abuse, In-Patient	Not covered	Coinsurance, $2,000 maximum benefit	Coinsurance, $2,000 maximun benefit
Alcohol/Substance Abuse Out-Patient	Not covered	Coinsurance, $2,000 maximum benefit	Coinsurance, $2,000 maximun benefit
Preventive Medical Services	$150 maximum	Coinsurance, $250 maximum per year	Coinsurance, $250 maximum per year
Organ Transplant	$200,000 lifetime maximum	Coinsurance	Coinsurance
Home Health Care	Covered in full, 60 visits per year	Coinsurance, 60 visits per year	Coinsurance, 60 visits per year

*Not included in out of pocket maximum

*Not included in out of pocket maximum

Rulemaking Authority 624.308, 627.6675(3)(c) FS. Law Implemented 624.307(1), 627.6498(4), 627.6675(3), 641.3922(3) FS. History New 3-2-00, Amended 4-2-01, 4-17-02, Formerly 4-149.204, Amended 5-18-04.

69O-149.204 Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

627.6675 Conversion on termination of eligibility.—

(3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR GROUP COVERAGE.—
(a) The premium for the converted policy shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. However, the premium for the converted policy may not exceed 200 percent of the standard risk rate as established by the office, pursuant to this subsection.
(b) Actual or expected experience under converted policies may be combined with such experience under group policies for the purposes of determining premium and loss experience and establishing premium rate levels for group coverage.
(c) The office shall annually determine standard risk rates, using reasonable actuarial techniques and standards adopted by the commission by rule. The standard risk rates must be determined as follows:
1. Standard risk rates for individual coverage must be determined separately for indemnity policies, preferred provider/exclusive provider policies, and health maintenance organization contracts.
2. The office shall survey insurers and health maintenance organizations representing at least an 80 percent market share, based on premiums earned in the state for the most recent calendar year, for each of the categories specified in subparagraph 1.
3. Standard risk rate schedules must be determined, computed as the average rates charged by the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.
4. The rate schedule shall be determined from analysis of the one county with the largest market share in the state of all such carriers.
5. The rate for other counties must be determined by using the weighted average of each carrier's county factor relationship to the county determined in subparagraph 4.
6. The rate schedule must be determined for different age brackets and family size brackets.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

641.3922 Conversion contracts; conditions.—Issuance of a converted contract shall be subject to the following conditions:

(3) CONVERSION PREMIUM.—The premium for the converted contract shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the

standard risk rate, as established by the office under s. 627.6675(3). The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

M E M O R A N D U M

DATE: September 29, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Stephen Fredrickson, Assistant General Counsel

SUBJECT: Cabinet Agenda for October 17, 2017
Request for Final Approval to Adopt Amendments to
Rules 69O-162.008,.012
Assignment # 207468-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before October 11, 2017, and to the Financial Services Commission on October 17, 2017, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on October 2, 2017.

The notice of proposed rules was published on August 21, 2017, in Volume 43, No. 162, of the *Register*. The hearing was not requested; therefore, the hearing was not held.

The rules are amended to cross reference the Annuity Mortality Tables listed in rule 69O-162.108 for policies issued prior to December 31, 2016, and to reference the NAIC Valuation Manual adopted by s. 625.1212, F.S., for policies issued on or after January 1, 2017.

Sections 624.308(1), 627.805, 624.307(1), 625.121, 627.802, 627.803, 627.804, 627.413, F.S., are the rulemaking authority and laws implemented for these rules.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee and confirmed that their review of the rules has been completed.

Stephen Fredrickson is the attorney handling these rules. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-162.008 Contract Provision; Expense, Mortality and Investment Increment Factor.

Any individual or group variable annuity contract delivered or issued for delivery in this state shall stipulate the expense, mortality, and investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and shall guarantee that expense and mortality results shall not adversely affect such dollar amounts. The mortality and investment increment factors used in computing the dollar amount of variable benefits or other contractual payments or values under an individual variable contract shall not produce a larger initial payment than would be produced by the use of annuity mortality tables in rule 69O-162.108 for policies issued on or before December 31, 2016 and ~~the 1937 Standard~~ ~~A~~annuity ~~M~~mortality ~~T~~tables for use in determining reserve liabilities in accordance with the NAIC Valuation Manual as adopted by s. 625.1212, F.S. for policies issued on or after January 1, 2017 and an annual investment increment assumption of 3 ½%. "Expense" as used in this subsection may exclude some or all taxes as stipulated in the contract.

Rulemaking ~~Specific~~ Authority 624.308(1), 627.805 FS. Law Implemented 624.307(1), 627.803, 627.804, 627.413 FS. History–Repromulgated 12-24-74, Formerly 4-10.08, 4-10.008, 4-162.008, Amended_____.

69O-162.012 Valuation of Account Assets; Reserve Liability.

(1) No Change

(2) The reserve liability for variable annuity contracts shall be established by the Office ~~Director~~ pursuant to the requirements of ~~the 1937 Standard~~ ~~A~~annuity ~~M~~mortality ~~T~~tables for use in determining reserve liabilities listed in rule 69O-162.108 for policies issued prior to December 31, 2016 and for use in determining reserve liabilities in accordance with the NAIC Valuation Manual as adopted by s. 625.1212, F.S. for policies issued on or after January 1, 2017 and ~~in Appendix VM-M of the NAIC Valuation Manual~~ in accordance with actuarial procedures that recognize the variable nature of the benefits provided.

Rulemaking Authority 627.805 FS. Law Implemented 625.121, 627.802, 627.804 FS. History–Repromulgated 12-24-74, Formerly 4-10.12, 4-10.012, 4-162.012, Amended_____.

69O-162.008,.012
Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.805 Regulation of variable and indeterminate value contracts; rules.—The Department of Financial Services and the Office of Insurance Regulation shall regulate the issuance and sale of variable and indeterminate value contracts pursuant to their respective authority as conferred by state law. The Office of Financial Regulation shall regulate the sale of variable and indeterminate value contracts pursuant to its authority under chapter 517. The Department of Financial Services and, when applicable, the Financial Services Commission, may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this part.

624.307 General powers; duties.—
(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

627.803 Statement of value of benefits.—Any contract or group certificate delivered or issued for delivery in this state which provides variable or indeterminate values shall contain a statement of the essential features of the procedure to be followed by the insurance company in determining the dollar amount of the benefits, values, or premiums and shall state in clear terms that the amount may decrease or increase according to such procedure. Any such contract delivered or issued for delivery in this state, and any such group certificate, shall contain on its first page, in a prominent position in contrasting color or boldfaced type, and in a type size as large as the type used in the text of the policy, a clear statement that the benefits, values, or premiums are on a variable basis and, if such is the fact, that the initial interest rate is guaranteed only for a limited period of time.

627.804 Investment of assets.—An insurer which issues contracts providing for benefits, values, or premiums that vary directly according to investment experience and which has established a separate account or accounts in connection with such contracts may invest and reinvest the assets held in the separate account or accounts without regard to any state requirements or limitations governing the investments of life insurance companies. The investments in the separate account or accounts shall not be considered in applying the investment limitations otherwise applicable to the investments of the company.

627.413 Contents of policies, in general; identification.—
(1) Every policy shall specify:
(a) The names of the parties to the contract.
(b) The subject of the insurance.
(c) The risks insured against.
(d) The time when the insurance thereunder takes effect and the period during which the insurance is to continue.
(e) The premium.
(f) The conditions pertaining to the insurance.
(g) The form numbers and edition dates or numeric code indicating edition dates, when such code has been supplied to the office, of all endorsements attached to a policy. This

requirement applies to life insurance policies and health insurance policies only at the time of original issue.
(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.
(3) Subsections (1) and (2) do not apply to surety contracts or to group insurance policies.
(4) All policies and annuity contracts issued by insurers, and the forms thereof filed with the office, shall have printed thereon an appropriate designating letter or figure, or combination of letters or figures or terms identifying the respective forms of policies or contracts. Whenever any change is made in any such form, the designating letters, figures, or terms thereon shall be correspondingly changed.
(5) Any policy that is a minimum premium policy issued by an insurer pursuant to the minimum premium provisions of rules adopted by rating organizations licensed by the office, shall have typed, printed, stamped, or legibly handwritten on the certificate the words "minimum premium policy" or equivalent language. The office may impose an administrative fine pursuant to s. 624.4211 if the office finds any violation of this subsection.
(6) Notwithstanding any other provision of the Florida Insurance Code that is in conflict with federal requirements for a health savings account qualified high-deductible health plan, an insurer, or a health maintenance organization subject to part I of chapter 641, which is authorized to issue health insurance in this state may offer for sale an individual or group policy or contract that provides for a high-deductible plan that meets the federal requirements of a health savings account plan and which is offered in conjunction with a health savings account.

625.121 Standard Valuation Law; life insurance.—
(1) SHORT TITLE.—This section shall be known as the "Standard Valuation Law."
(2) ANNUAL VALUATION.—The office shall annually value, or cause to be valued, the reserves for all outstanding life insurance policies and annuity and pure endowment contracts of each life insurer doing business in this state. In the case of an alien insurer, such valuation is limited to its insurance transactions in the United States. In calculating reserves, the office may use group methods and approximate averages for fractions of a year or otherwise, and may accept the insurer's calculation of such reserves. In lieu of the valuation of the reserves required of a foreign or alien insurer, the office may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction if the valuation complies with the minimum standard provided under this section. If a valuation is made by the office, the office may use its actuary or employ an actuary for that purpose; and the reasonable compensation of the actuary, at a rate approved by the office, plus reimbursement of travel expenses pursuant to s. 624.320, supported by an itemized statement of such compensation and expenses, shall be paid by the insurer upon demand of the office. If a domestic insurer furnishes the office with a valuation of its outstanding policies as computed by its own actuary or by an actuary deemed satisfactory for that purpose by the office, the valuation shall be verified by the actuary of the office without cost to the insurer. This section applies to the calculation of reserves for policies and contracts not subject to s. 625.1212.
(3) ACTUARIAL OPINION OF RESERVES.—
(a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commission by rule

shall define the specifics of this opinion and add any other items determined necessary to its scope.

1. The opinion shall be submitted with the annual statement and must reflect the valuation of such reserve liabilities for each year ending on or before December 31 of the year before the operative date of the valuation manual as defined in s. 625.1212(2), and in accordance with s. 625.1212(4) for each year thereafter.

2. The opinion applies to all business in force, including individual and group health insurance plans, in the form and substance acceptable to the office as specified by rule of the commission.

3. The commission may adopt rules providing the standards of the actuarial opinion consistent with standards adopted by the Actuarial Standards Board on December 31, 2013, and subsequent revisions thereto if the standards remain substantially consistent.

4. The office may accept an opinion filed by a foreign or alien insurer with the insurance supervisory official of another state if the office determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.

5. As used in this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who also meets the requirements specified by rule of the commission.

6. Disciplinary action by the office against the insurer or the qualified actuary shall be in accordance with the insurance code and related rules adopted by the commission.

7. A memorandum in the form and substance specified by rule shall be prepared to support each actuarial opinion.

8. If the insurer fails to provide a supporting memorandum at the request of the office within a period specified by rule of the commission, or if the office determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by rule of the commission, the office may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as required by the office.

9. Except as otherwise provided in this subparagraph, any memorandum or other material in support of the opinion is confidential and exempt from s. 119.07(1) and is not subject to subpoena or discovery directly from the office; however, the memorandum or other material may be released by the office with the written consent of the insurer, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the office for preserving the confidentiality of the memorandum or other material. If any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, no portion of the memorandum is confidential. Neither the office nor any person who receives documents, materials, or other information while acting under the authority of the office or with whom such information is shared pursuant to this paragraph may testify in a private civil action concerning the confidential documents, materials, or information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. A waiver of an applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the office under this section or any other section of the insurance code, or as a result of sharing as authorized under s. 624.4212.

(b) In addition to the opinion required by paragraph (a), the office may, pursuant to commission rule, require an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including, but not limited to, the

investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including, but not limited to, the benefits under, and expenses associated with, the policies and contracts.
(c) The commission may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.
(4) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED BEFORE OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.—The minimum standard for the valuation of all such policies and contracts issued prior to the operative date of s. 627.476 (Standard Nonforfeiture Law) shall be any basis satisfactory to the office. Any basis satisfactory to the former Department of Insurance on the effective date of this code shall be deemed to meet such minimum standards.
(5) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF THE STANDARD NONFORFEITURE LAW.—Except as otherwise provided in paragraph (h) and subsections (6), (13), and (14), the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of s. 627.476 shall be the commissioners' reserve valuation method defined in subsections (7), (11), and (14); 5 percent interest for group annuity and pure endowment contracts and 3.5 percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, 4 percent interest for such policies issued prior to October 1, 1979, and 4.5 percent interest for such policies issued on or after October 1, 1979; and the following tables:
(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies:
1. For policies issued before the operative date of s. 627.476(9), the 1958 Commissioners Standard Ordinary (CSO) Mortality Table; except that, for any category of such policies issued on female risks, modified net premiums and present values, referred to in subsection (7), may be calculated according to an age up to 6 years younger than the actual age of the insured.
2. For policies issued on or after the operative date of s. 627.476(9), the 1980 Commissioners Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the 1980 Commissioners Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.
3. For policies issued on or after July 1, 2004, ordinary mortality tables, adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for such policies.
(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies:
1. For policies issued before the first date, the 1961 Commissioners Standard Industrial Mortality Table is applicable according to s. 627.476, the 1941 Standard Industrial Mortality Table;
2. For policies issued on or after that date, the 1961 Commissioners Standard Industrial Mortality Table; and
3. For policies issued on or after October 1, 2014, a Commissioners Standard Industrial Mortality Table adopted by the NAIC after 1980 which is adopted by rule of the commission for use in determining the minimum standard of valuation for such policies.
(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of these tables approved by the office.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951; any modification of such table approved by the office; or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.
(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:
1. For policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit;
2. For policies or contracts issued on or after January 1, 1961, and before January 1, 1966, either of the tables specified in subparagraph 1. or, at the option of the insurer, the class three disability table (1926);
3. For policies issued before January 1, 1961, the class three disability table (1926); and
4. For policies or contracts issued on or after July 1, 2004, tables of disablement rates and termination rates adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies or contracts.

Any such table for active lives shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies:
1. For policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table;
2. For policies issued on or after January 1, 1961, and before January 1, 1966, the 1959 Accidental Death Benefits Table or, at the option of the insurer, the Intercompany Double Indemnity Mortality Table;
3. For policies issued before January 1, 1961, the Intercompany Double Indemnity Mortality Table; and
4. For policies issued on or after July 1, 2004, tables of accidental death benefits adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the office as being sufficient with relation to the benefits provided by such policies.
(h) Except as provided in subsection (6), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the commissioners' reserve valuation method defined in subsection (7) and the following tables and interest rates:
1. For individual annuity and pure endowment contracts issued before October 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest for single-premium immediate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts.
2. For individual single-premium immediate annuity contracts issued on or after October 1, 1979, and before October 1, 1986, excluding any disability and accidental death benefits in

such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
3. For individual annuity and pure endowment contracts issued on or after October 1, 1979, and before October 1, 1986, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 5.5 percent interest for single-premium deferred annuity and pure endowment contracts and 4.5 percent interest for all other such individual annuity and pure endowment contracts. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
4. For all annuities and pure endowments purchased before October 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest.
5. For all annuities and pure endowments purchased on or after October 1, 1979, and before October 1, 1986, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts purchased on or after October 1, 1986, the 1983 Group Annuity Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

After July 1, 1973, an insurer may have filed with the former Department of Insurance a written notice of its election to comply with this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer does not make such election, the operative date of this paragraph for such insurer is January 1, 1979.

(i) In lieu of the mortality tables specified in this subsection, and subject to rules previously adopted by the former Department of Insurance, the insurance company may, at its option:
1. Substitute the applicable 1958 CSO or CET Smoker and Nonsmoker Mortality Tables, in lieu of the 1980 CSO or CET mortality table standard, for policies issued on or after the operative date of s. 627.476(9) and before January 1, 1989.
2. Substitute the applicable 1980 CSO or CET Smoker and Nonsmoker Mortality Tables in lieu of the 1980 CSO or CET mortality table standard.
3. Use the Annuity 2000 Mortality Table for determining the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after January 1, 1998, and before July 1, 1998.
4. Use the 1994 GAR Table for determining the minimum standard of valuation for annuities and pure endowments purchased on or after January 1, 1998, and before July 1, 1998, under group annuity and pure endowment contracts.
(j) The commission may adopt by rule the model regulation for valuation of life insurance policies as approved by the NAIC in March 1999, including tables of select mortality factors, and may make the regulation effective for policies issued on or after January 1, 2000.
(k) For individual annuity and pure endowment contracts issued on or after July 1, 2004, excluding disability and accidental death benefits purchased under those contracts,

individual annuity mortality tables adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.
(l) For all annuities and pure endowments purchased on or after July 1, 2004, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under those contracts, group annuity mortality tables adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.
(6) MINIMUM STANDARD OF VALUATION.—
(a) The interest rates used in determining the minimum standard for the valuation of:
1. All life insurance policies issued in a particular calendar year on or after the operative date of s. 627.476(9);
2. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;
3. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and
4. The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts,

shall be the calendar year statutory valuation interest rates for the year-of-issue purchase or increase as defined in this subsection.

(b) The calendar year statutory valuation interest rates I shall be determined as follows, and the results rounded to the nearest 0.25 percent:
1. For life insurance:

$I = 0.03 + W(R1-0.03) + (W/2)(R2-0.09)$.

For purposes of this subparagraph, "R1" is the lesser of R and .09; "R2" is the greater of R and .09; "R" is the reference interest rate defined in this subsection; and "W" is the weighting factor defined in this subsection.

2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$I = 0.03 + W(R-0.03)$.

For purposes of this subparagraph, "R" is the reference interest rate defined in this subsection, and "W" is the weighting factor defined in this subsection.

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue-year basis, except as stated in subparagraph 2., the formula for life insurance stated in subparagraph 1. shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single-premium immediate annuities stated in subparagraph 2. shall apply to annuities and guaranteed interest contracts with guarantee durations of 10 years or less.
4. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.
5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 0.5 percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, the reference interest rate defined for 1979 being used, and shall be determined for each subsequent calendar year regardless of when s. 627.476(9) becomes operative.

(c) The weighting factors referred to in the formulas stated in paragraph (b) are given in the following tables:

1. Weighting factors for life insurance:

Guarantee Duration Weighting

(Years) Factors

10 or less:.....0.50

More than 10, but not more than 20:.....0.45

More than 20:.....0.35

For life insurance, the "guarantee duration" is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

2. Weighting factor for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: 0.80.

3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph 2., shall be as specified in sub-subparagraphs a., b., and c., according to the rules and definitions in sub-subparagraphs d., e., and f. and in paragraph (f):

a. For annuities and guaranteed interest contracts valued on an issue-year basis:

Guarantee Duration Weighting Factor

(Years) for Plan Type

5 or less:.....A—0.80

B—0.60

C—0.50

More than 5, but not more than 10:.....A—0.75

B—0.60

C—0.50

More than 10, but not more than 20:.....A—0.65

B—0.50

C—0.45

More than 20:.....A—0.45

B—0.35

C—0.35

b. For annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in sub-subparagraph a. increased by: 0.15 for Plan Type A; 0.25 for Plan Type B; 0.05 for Plan Type C.
c. For annuities and guaranteed interest contracts valued on an issue-year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in sub-subparagraph a. or derived in sub-subparagraph b. increased by: 0.05 for Plan Type A; 0.05 for Plan Type B; 0.05 for Plan Type C.
d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the "guarantee duration" is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.
e. "Plan type," as used in the tables above, is defined as follows:
(I) Plan Type A: At any time, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; the policyholder may withdraw funds only as an immediate life annuity; or no withdrawal is permitted.
(II) Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; or no withdrawal is permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than 5 years.
(III) Plan Type C: The policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years either without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.
f. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis.

(d) The "reference interest rate" referred to in paragraph (b) is defined as follows:
1. For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the interest rate index.
2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the interest rate index.
3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
5. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
6. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in subparagraph 2., the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the interest rate index.
(e) The interest rate index shall be the Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., if the index is calculated by using substantially the same methodology used by Moody's on January 1, 1981. If Moody's corporate bond yield average ceases to be calculated in substantially the same manner, the interest rate index shall be the index specified in the valuation manual, as applicable, as provided under s. 625.1212, or an index adopted by the NAIC and approved by rule adopted by the commission. The methodology used in determining the index approved by rule must be substantially the same as the methodology employed on January 1, 1981, for determining Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc.
(f) As used in this subsection, an "issue-year basis" of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of purchase of the annuity or guaranteed interest contract; and the "change-in-fund" basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.
(7) COMMISSIONERS' RESERVE VALUATION METHOD.—
(a)1. Except as otherwise provided in this subsection and subsections (11) and (14), reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then-present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then-

present value of such benefits provided for by the policy and the excess of sub-subparagraph a. over sub-subparagraph b. as follows:
a. A net-level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net-level annual premium shall not exceed the net-level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of such policy.
b. A net-1-year-term premium for such benefits provided for in the first policy year.
2. For any life insurance policy which is issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners' reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium, shall, except as otherwise provided in subsection (11), be the greater of the reserve as of such policy anniversary calculated as described in subparagraph 1. and the reserve as of such policy anniversary calculated as described in subparagraph 1. but with:
a. The value defined in subparagraph 1. being reduced by 15 percent of the amount of such excess first year premium;
b. All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;
c. The policy being assumed to mature on such date as an endowment; and
d. The cash surrender value provided on such date being considered as an endowment benefit.

In making the above comparison, the mortality and interest bases stated in subsections (5) and (6) shall be used.

(b) Reserves according to the commissioners' reserve valuation method for:
1. Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;
2. Group annuity and pure endowment contracts, purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of the Internal Revenue Code, as now or hereafter amended;
3. Disability and accidental death benefits in all policies and contracts; and
4. All other benefits, except life insurance and endowment benefits in life insurance policies, and benefits provided by all other annuity and pure endowment contracts,

shall be calculated by a method which is consistent with and yields results consistent with the principles of paragraph (a).

(c) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of

the Internal Revenue Code, as now or hereafter amended. Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(8) MINIMUM AGGREGATE RESERVES.—

(a) In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of s. 627.476, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (7), (11), and (12) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(b) In no event may the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by subsection (3).

(9) OPTIONAL RESERVE BASIS.—

(a) Reserves for all policies and contracts issued prior to the operative date of s. 627.476 may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

(b) For any category of policies, contracts, or benefits specified in subsections (5) and (6), issued on or after the operative date of s. 627.476 (the Standard Nonforfeiture Law for Life Insurance), reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided; but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.

(10) LOWER VALUATIONS.—An insurer that adopted a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this section shall, with the approval of the office, adopt a lower standard of valuation, but not lower than the minimum herein provided; however, for the purposes of this subsection, the holding of additional reserves previously determined by an appointed actuary, as defined in s. 625.1212(2), to be necessary to render the opinion required by subsection (3) may not be deemed to be the adoption of a higher standard of valuation.

(11) ADDITIONAL PREMIUM.—If in any contract year the gross premium charged by a life insurer on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum premium reserve required for the policy or contract shall be the greater of the reserve calculated according to the actual mortality table, rate of interest, and method used for the policy or contract, or the actual method used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest are those standards defined by subsections (4), (5), and (6). For any

life insurance policy that is issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored. The minimum premium reserve amount, if any, at each policy anniversary of such a policy is the excess, if any, of the amount determined by the foregoing provisions of this subsection plus the reserve calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored, over the reserve actually calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being taken into account.

(12) RESERVE CALCULATION FOR INDETERMINATE PREMIUM PLANS.—In the case of a plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity for which the minimum reserves cannot be determined by the methods described in subsections (7) and (11), the reserves that are held under such plan must:

(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) Be computed by a method that is consistent with the principles of this section, as determined by rules adopted by the commission.

(13) CREDIT LIFE AND DISABILITY POLICIES.—

(a) For policies issued prior to January 1, 2004:

1. The minimum reserve for single-premium credit disability insurance, monthly premium credit life insurance, and monthly premium credit disability insurance shall be the unearned gross premium.

2. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table and 3.5 percent interest. At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.

(b) For policies issued on or after January 1, 2004:

1. The minimum reserve for single-premium credit disability insurance shall be either:

a. The unearned gross premium, or

b. Based upon a morbidity table that is adopted by the National Association of Insurance Commissioners and is specified in a rule the commission adopts pursuant to subsection (14).

2. The minimum reserve for monthly premium credit disability insurance shall be the unearned gross premium.

3. The minimum reserve for monthly premium credit life insurance shall be the unearned gross premium.

4. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule adopted by the commission for use in determining the minimum standard of valuation for such policies; and an interest rate determined in accordance with subsection (6). At the discretion of the office, the insurer may make a reasonable

assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.
(14) MINIMUM STANDARDS FOR HEALTH PLANS.—The commission shall adopt a rule containing the minimum standards applicable to the valuation of health plans in accordance with sound actuarial principles.

627.802 Establishment and maintenance of separate accounts.—A domestic life insurance company may establish one or more separate accounts and allocate thereto 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. All amounts received by the company which are required by contract to be applied to provide variable benefits or values shall be added to the appropriate separate account. If so provided under applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct. Any deficit from mortality experience which may arise in any such separate account shall be adjusted by additions to the account by the company so that the assets of the account are always at least equal to the assets required to satisfy the obligations of the company.

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Number	Description	Weight	Bench-mark	Scale	Result	Counts	Score
1	Average* number of days to process applications with a benchmark** score of 3.	8%	35.42	5 = 34.71 4 = 35.07 3 = 35.42 2 = 35.77 1 =36.13	35.42	59	3
2	Average* number of days to complete life and health form and rate filing reviews with a benchmark** score of 3.	8%	22.09	5 = 21.65 4 = 21.87 3 = 22.09 2 = 22.31 1 =22.53	22.09	1416	3
3	Average* number of days to complete property and casualty form and rate filing reviews with a benchmark** score of 3.	8%	20.90	5 = 20.48 4 = 20.69 3 = 20.90 2 = 21.11 1 =21.32	20.90	2165	3
4	Weighted average of the percentages for completed applications/filings within: 90 days for COA's and new types of insurance; 45 days for L&H; 90 days for P&C rates and 45 days for forms; 60/90 days for priority/non-priority financial analyses; and total market conduct violations requiring remediation.	8%	100%	5 = 98 -100% 4 = 95 - 97% 3 = 92 - 94% 2 = 90 - 92% 1 = 87-89%	99.6%		5
5	Average* number of days to complete market conduct exams and investigations with a benchmark** score of 3.	8%	88.7	5 = 86.93 4 = 87.81 3 = 88.70 2 = 89.57 1 = 90.47	81.9	170	5
6	Percentage of financial exams of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	100%	42	5
7	Percentage of life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	100%	6	5
8	Percentage of property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	100%	36	5
9	Average* number of days to complete priority financial analyses with a benchmark** score of 3.	8%	8.64	5 = 8.47 4 = 8.55 3 = 8.64 2 = 8.73 1 = 8.81	8.64	112	3
10	Average* number of days to complete non-priority financial analyses with a benchmark** score of 3.	8%	42.24	5 = 41.40 4 = 41.82 3 = 42.24 2 = 42.66 1 = 43.08	42.24	2797	3
						Avg.	4

** Average refers to an eight-quarter moving weighted average to reduce the effects of seasonality and create a stable dataset.*