NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by 1st submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Due to time restraints, the Secretary of State's Office will no longer edit the text of proposed rules. We will continue to make numbering and labeling changes as necessary.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 30. BOARD OF TECHNICAL REGISTRATION

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

Sections Affected	Rulemaking Action
R4-30-101	Amend
R4-30-106	Amend
R4-30-120	Amend
R4-30-121	Amend
R4-30-122	Amend
R4-30-123	Amend
R4-30-124	Amend
R4-30-126	Amend
R4-30-208	Amend
R4-30-212	Amend
R4-30-214	Amend
R4-30-221	Amend
R4-30-222	Amend
R4-30-224	Amend
R4-30-242	Amend
R4-30-244	Amend
R4-30-252	Amend
R4-30-254	Amend
R4-30-262	Amend
R4-30-264	Amend
R4-30-282	Amend
R4-30-284	Amend
R4-30-301	Amend
R4-30-304	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. §§ 32-106(A)(1), (5), (6), and (9); 32-106(F)

   Implementing statutes: A.R.S. §§ 32-106.02(A), 32-122(A) and (B); 32-122.01 (D) and (E); 32-124(A)

3. **A list of all previous notices appearing in the Register addressing the proposed rules:**

   Notice of Rulemaking Docket Opening: 4 A.A.R. 1347-1348, June 12, 1998.
   Notice of Rulemaking Docket Opening (R4-30-224): 4 A.A.R. October 30, 1998.

4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: LaVern Douglas

   Address: Board of Technical Registration
   1951 West Camelback Road, Suite 250
   Phoenix, Arizona 85015-3470

Telephone: (602) 255-4053

Fax: (602) 255-4051

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**
The rules cover general, registration, and regulatory provisions for professional registration.

6. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
Not applicable.

7. **A showing of good cause why the rules are necessary to promote a statewide interest if the rule will diminish a previous grant of a political subdivision of the state:**
Not applicable.

8. **The preliminary summary of the economic, small business, and consumer impact:**
No anticipated negative impact from this change on small business or consumers.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**
Name: LaVern Douglas

Address: Board of Technical Registration
1951 West Camelback Road, Suite 250
Phoenix, Arizona 85015-3470

Telephone: (602) 255-4053

Fax: (602) 255-4051

10. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule; or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**
A public meeting is scheduled for January 8, 1998, at 10 a.m., in the Board office conference room located at 1951 West Camelback Road, Phoenix.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **The full text of the rules follows:**

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 30. BOARD OF TECHNICAL REGISTRATION

ARTICLE 1. GENERAL PROVISIONS

Section
R4-30-101. Definitions
R4-30-106. Fees
R4-30-120. Complaint Review Process
R4-30-121. Investigation of Violations
R4-30-122. Issuance of Subpoenas
R4-30-123. Informal Compliance Procedures
R4-30-124. Hearings
R4-30-126. Service of Board Decisions; Rehearing of Board's Decisions

ARTICLE 2. REGISTRATION PROVISIONS

R4-30-208. Educational and Work Experience Requirements
R4-30-212. Architect-in-training ~~registration~~ Designation Requirements
R4-30-214. Architect Registration Requirements
R4-30-221. Engineering Branches Recognized
R4-30-222. Engineering-in-training ~~registration~~ Designation Requirements
R4-30-224. Engineer Registration Requirements
R4-30-242. Geologist-in-training ~~registration~~ Designation Requirements
R4-30-244. Geologist Registration Requirements
R4-30-252. Landscape Architect-in-training Registration Requirements
R4-30-254. Landscape Architect Registration Requirements
R4-30-262. Assayer-in-training ~~registration~~ Designation Requirements
R4-30-264. Assayer Registration Requirements
R4-30-282. Land Surveyor-in-training ~~registration~~ Designation Requirements
R4-30-284. Land Surveyor Registration Requirements

ARTICLE 3 REGULATORY PROVISIONS

R4-30-301. Rules of Professional Conduct
R4-30-304. Use of Seals

ARTICLE 1. GENERAL PROVISIONS

R4-30-101. Definitions

No change.
1. No change.
2. No change.
3. "Bona fide employee" means:

a. Any person employed by a Town, City, County, State or Federal agency working under the direction or supervision of a registrant;
b. Any person employed by a business entity working under the direct supervision of a registrant who is also employed by the same business entity; or
c. Any ~~individual~~ person working under the direct supervision of a registrant who:
~~a.~~1. Receives direct wages from the registrant; ~~or~~
~~b.~~2. Receives contract compensation from the registrant; or
~~c.~~3. Receives direct wages from the project prime professional who has a contract with another registrant, and whose work product is the responsibility of the latter registrant.

7. "Direct supervision" means a registrant's critical examination and evaluation of the work product, during and after the preparation, for purposes of compliance with applicable laws, codes, ordinances and regulations pertaining to the registrant's professional practice.
8. No change.
9. No change.
10. "Good moral character and repute" shall be established if the registration candidate:
a. Has not been convicted of a class one felony;
~~a.~~b. Has not ~~, within five years of application for registration,~~ been convicted of a felony or misdemeanor if such offense has a reasonable relationship to the functions of the employment or ~~occupation~~ category for which the ~~license or certificate~~ registration or designation is sought;
~~b.~~c. Has not, within five years of application for registration, committed any act involving dishonesty, fraud, misrepresentation, breach of fiduciary duty, gross negligence or incompetence reasonably related to the candidate's proposed area of practice;
~~c.~~d. Is not currently incarcerated in a penal institution;
~~d.~~e. Has not engaged in fraud or misrepresentation in connection with ~~this~~ the application for registration or related examination;
~~e.~~f. Has not had a registration revoked or suspended for cause by this State or by any other jurisdiction, or surrendered a professional license in lieu of disciplinary action; ~~or~~
~~f.~~g. Has not practiced without the required registration in the State or in another jurisdiction ~~within the United States~~ within the two years immediately preceding the filing of the application for registration; or
h. Has not, within five years of application for registration, committed an act that would constitute unprofessional conduct, as set forth in rule R4-30-301.

13. "Other misconduct" means the registrant:
a. Has been convicted of a class one felony;
~~a.~~b. Has been convicted of a felony or misdemeanor, if such offense has a reasonable relationship to the functions of the ~~license~~ registration;
~~b.~~c. No change.
~~c.~~d. Has had a professional license or registration suspended or revoked for cause by this State or by any other jurisdiction or has surrendered a professional license in lieu of disciplinary action; ~~or~~
~~d.~~e. Has knowingly acted in violation of, or knowingly failed to act in compliance with any provisions of the Act or rules of the Board or any State, Municipal or County law, code, ordinance or regulation, pertaining to the practice of the registrant's professional practice~~.~~; or
~~e.~~f. No change.

16. "Professional documents" mean drawings, prints, maps, plats, site plans, reports, specifications, calculations, or other documents that require professional judgment, design, analysis, or conclusions.
~~16.~~17. "Project Prime Professional" means the ~~person~~ registrant responsible for the coordination, continuity and compatibility of the various collaborating ~~professional's~~ registrant's work (when retained by the project prime professional).

R4-30-106. Fees

A. ~~The triennial renewal fee is $126.~~ The Board may charge the following fees:
1. Triennial renewal fee is $126.
2. Delinquent renewal fee is $21.00 per year or any fraction of a year that the renewal is delinquent.
3. A Roster of Registrants is $15.00.
4. A Code and Rule booklet is $5.00.
5. Computer printout fee per name is $.10 (non-commercial use). The maximum charge is $150.00 per run.
6. Photocopy charge fee is $.20 per page (non-commercial use).
7. Replacement certificates fee is $10.00.
8. Audio tape copy fee is $10.00 each.
9. Local examination review fee is $25.00.
10. Returned check fee is $25.00.

B. Payment of fees shall be in United States dollars in the form of cash, check, or money order; however, if a check is returned for insufficient funds, repayment, including payment of the returned check charge, shall be made in cash, or by money order or certified check.

C. Upon written request, the Board shall waive renewal fees for registrants ~~who are retired from active practice and who have attained the age of 65 or more years during the immediately preceding registration period.~~ whose registration is in inactive status.

D. No application fee refunds will be allowed after the application has been assigned an application number and processing commences.

R4-30-120. Complaint Review Process

A. The ~~Board~~ Executive Director shall ~~appoint~~ select registrants and public members to enforcement advisory committees as needed. Each committee shall have as a minimum of four registrants, at least one of whom is registered in the same category or branch as the respondent, and one public member. ~~These~~ The committees shall be volunteers ~~used by~~ staff, which provide technical assistance to Board staff in the evaluation and ~~the disposition~~ investigation of complaints. Members are to be selected from a pool of volunteers submitting resumes and letter of interest, which are pre-approved by the Board.

B. During the preliminary informal investigation of a complaint registrants named as respondents ~~shall be offered an opportunity to~~ may appear before an enforcement advisory committee for an informal conference relating to the complaint. Respondents may elect to appear with or without counsel. ~~The committee will be comprised of registrants, at least one of which is registered in the same category and/or branch as the respondent, and a public member.~~ The committee shall attempt to assess the complaint and discuss the complaint

with the respondent and others, if deemed necessary, and prepare a recommendation for the disposition of the complaint.

C. No change.

D. If a respondent chooses not to attend the informal conference the committee may meet and review information presented by staff and others, and prepare a recommendation for disposition of the complaint.

E. The Board shall advise the respondent ~~shall be advised~~ of the committee recommendation, and ~~shall be offered~~ offer the respondent the opportunity to attend an informal compliance conference as outlined in R4-30-123 as part of the informal investigation.

F. After the informal investigation has been completed, if the committee recommendation supports a determination that the complaint is unfounded, the recommendation shall be forwarded to the Board for review and final disposition.

G. In all cases where the advisory committee finds probable cause to believe that disciplinary action is warranted, the staff will attempt to obtain a signed consent ~~order~~ agreement. ~~for review by the Board.~~ The Board shall ~~be presented~~ review the committee recommendation, ~~a~~ staff recommendation, consent agreement, and, in the event a signed consent ~~order~~ agreement cannot be obtained, any counter proposal from the respondent.

R4-30-121. Investigation of Violations

If any information concerning a possible violation of the Act, or any of these Rules should be received or obtained by the Board or Board staff, an investigation shall be conducted prior to the initiation of formal proceedings. Investigative reports, enforcement advisory committee recommendations and other documents and materials relating to an investigation shall remain confidential until the matter is closed, until the issuance of a hearing notice pursuant to A.R.S. § 32-126, or until the matter is settled by consent order; however, the Board shall inform the Respondent ~~registrant will be informed and the public may obtain information~~ that an investigation is being conducted. The public may obtain information that an investigation is being conducted and its general nature. The Board may refer investigative information to other public agencies as appropriate under the circumstances.

R4-30-122. Issuance of Subpoenas

Any party desiring the Board or its hearing officers to issue a subpoena shall make application, stating the substance of the testimony expected of the witness or the relevancy of the evidence to be produced. If such testimony or evidence appears to the Board or its hearing officer to be material and necessary, a subpoena shall be supplied. The affixing of the seal of the Board and the signature of the Chairman, ~~or~~ Secretary, Executive Director, or hearing officer shall be sufficient attestation of the same. Service of a subpoena shall be made at the expense of the party applying for it and ~~shall be made in the manner provided by laws for service of subpoenas in civil actions~~ shall be effective by personal service or by mailing a copy by certified mail that is addressed to the person's last known address.

R4-30-123. Informal Compliance Procedures

A. Upon notification of the ~~findings of an investigation by~~ recommendations of an enforcement advisory committee, a registrant may attend an informal compliance conference with Board staff. The registrant may appear ~~either~~ with or without counsel. The Board shall mail the ~~N~~notice of the compliance conference ~~shall be mailed~~ to the registrant at least 15 days prior to the date of the conference. The purpose of the compliance conference shall be to discuss informal settlement of the investigative matter. Upon completion of the interview, the Board's enforcement officer shall make recommendations to the Board.

B. No change.

R4-30-124. Hearings

A. All hearings before the Board~~,~~ or a ~~Board-appointed~~ hearing officer~~,~~ shall be held in accordance with A.R.S. § 32-128 and the adjudicative proceedings article of the Administrative Procedures Act A.R.S. §§ 41-1061 through 41-1066.

B. If the Respondent fails to answer the complaint or fails to appear at the hearing, the Board or hearing officer may vacate the hearing, and deem the acts and violations charged in the complaint admitted, and impose any of the sanctions provided by A.R.S. § 32-128.

R4-30-126. Service of Board Decisions; Rehearing of Board's Decisions

A. Except as provided in Subsection G, any party in a contested case before the Board who is aggrieved by a decision rendered in a case may file with the Board, not later that ~~ten~~ thirty days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds thereof. A decision shall be deemed to have been served when personally delivered or mailed by certified mail to the party's last known residence or place of business. The filing of a motion for rehearing is a condition precedent to the right of appeal provided in A.R.S. § 32-128(H).

B. A motion for rehearing under this Rule may be amended at any time before it is ruled on by the Board. A response may be filed within ~~ten~~ fifteen days after service of such motion or amended motion by any other party. The Board may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument. The filing of a motion for rehearing or review suspends the operation of the Board's order and allows the registrant to practice in his or her profession pending denial or granting of the motion, and pending the decision of the Board on the rehearing or review if the motion is granted.

C. No change.

D. No change.

E. Not later than ~~ten~~ thirty days after a decision is rendered, the Board may on its own ~~initiative~~ motion order a rehearing or review of its decision for any reason ~~for which it might have granted a rehearing or review of its decision on motion of a party~~ listed in subsection C of this rule. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing for a reason not stated in the motion. In either case the order granting such a rehearing shall specify the grounds therefor.

F. No change.

G. No change.

ARTICLE 2. REGISTRATION PROVISIONS

R4-30-208. Educational and Work Experience Requirements

A. No change.

B. ~~Work experience shall be credited~~ The Board shall credit work experience as follows:

1. One hundred and thirty hours or more of work per month is equal to one month of work experience.
2. Between ~~E~~eighty-five hours and one hundred and twenty-nine hours of work per month is equal to one-half month of work experience.
3. The Board shall not grant ~~No~~ credit ~~shall be granted~~ for less than eighty-five hours of work experience in a month.

4. Experience shall be substantiated by the employer before the Board grants the credit. ~~may be granted~~.

R4-30-212. Architect-in-training ~~registration~~ Designation Requirements

A. No change.

B. No change.

C. A candidate shall ~~take and pass~~ successfully complete the architect-in-training examination ~~administered~~ designated by the Board and provided by the National Council of Architectural Registration Boards. ~~A candidate shall receive a minimum score of 75% as established by the Board on each section (division) of the architect-in-training examination to complete successfully this requirement.~~

R4-30-214. Architect Registration Requirements

A. A candidate shall provide evidence of diverse work experience, which ~~that~~ is of a character acceptable to the Board, that includes, but is not limited to, each of the areas outlined in table H of the 1997-98 guidelines of the Intern Development Program (Appendix A), or the following areas:

1. Programming,
2. Site and Environmental Analysis,
3. Schematic Design,
4. Engineering Systems,
5. Building Cost Analysis,
6. Code Research,
7. Design Development,
8. Construction Documents,
9. Specifications and Material Research,
10. Document Checking and Coordination,
11. Bidding and Contract Negotiation,
12. Construction Phase - Office,
13. Construction Phase - Field Observation,
14. Project Management, and
15. Office Management

The Board shall not dictate minimum time requirements for each area of work experience.

~~A.~~**B.** A candidate shall ~~take and pass~~ successfully complete the professional architect examination ~~administered~~ designated by the Board and provided by the National Council of Architectural Registration Boards. ~~A candidate shall receive a minimum score of 75% as established by the Board on each section (division) of the professional examination to complete successfully this requirement.~~

~~B.~~**C.** Candidates seeking registration under the provisions of A.R.S. § 32-126(A) and registered by 36-hour examination prior to December 1965 in states other than Alaska, California, Colorado, Guam, Hawaii, Idaho, Nevada, New Mexico, Oregon, Utah, or Washington, or by education and experience only, shall ~~be required to take and pass~~ successfully complete a seismic structural technology examination ~~administered~~ designated by the Board and provided by the National Council of Architectural Registration Boards. ~~A candidate shall receive a minimum score of 75% as established by the Board on this examination to successfully complete this requirement.~~

R4-30-221. Engineering Branches Recognized

A. The Board shall recognize the branches of engineering described below for purposes of review of experience, selection of examination to be administered, ~~and~~ definition of areas of examination to be administered, and definition of areas of demonstrated proficiency to be inscribed on the seal. The ~~categories~~ branches shall not be construed to limit the areas of a registrant's practice of engineering. (See ~~R4-30-301.A. Paragraphs 10, 11 and 12)~~ R4-30-301(10, (11), and (12)).

1. No change.
2. No change.
3. No change.
4. No change.
5. No change.
6. No change.
7. No change.
8. No change.
9. No change.
10. No change.
11. No change.
12. No change.
13. No change.
14. No change.
15. No change.
16. No change.
17. No change.

B. No change.

R4-30-222. Engineering-in-training ~~registration~~ Designation Requirements

A. No change.

B. No change.

C. A candidate shall ~~take and pass~~ successfully complete the engineer-in-training examination ~~administered~~ designated by the Board and provided by the National Council of Examiners for Engineers and Surveyors. ~~A candidate shall receive a minimum score of 70% as established by the Board on the examination to complete successfully this requirement.~~

R4-30-224. Engineer Registration Requirements

A. No change.

B. No change.

C. No change.

~~**D.** A candidate shall receive a minimum score of 70% as established by the Board on the examination or, if a structural candidate, on each part of the examination to complete successfully this requirement.~~

R4-30-242. Geologist-in-training ~~registration~~ Designation Requirements

A. No change.

B. No change.

C. A candidate shall ~~take and pass~~ successfully complete the geologist-in-training examination ~~administered~~ designated by the Board and provided by the Association of State Boards of Geology. ~~A candidate shall receive a minimum score of 70% as established by the Board on the examination to complete successfully this requirement~~.

R4-30-244. Geologist Registration Requirements

A candidate shall ~~take and pass~~ successfully complete the professional geologist examination ~~administered~~ designated by the Board and provided by the Association of State Boards of Geology. ~~A candidate shall receive a minimum score of 70% as established by the Board on the examination to complete successfully this requirement.~~

R4-30-252. Landscape Architect-in-training Registration Requirements

A. No change.

B. No change.

C. A candidate shall ~~take and pass~~ successfully complete the landscape architect-in-training examination ~~administered~~ designated by the Board and provided by the Council of

Landscape Architectural Registration Boards. ~~A candidate shall receive a minimum score of 75% as established by the Board on each examination subject to complete successfully this requirement.~~

R4-30-254. Landscape Architect Registration Requirements

A candidate shall ~~take and pass~~ successfully complete the professional landscape architect examination ~~administered~~ designated by the Board and provided by the Council of Landscape Architectural Registration Boards. ~~A candidate shall receive a minimum score of 75% as established by the Board on each examination subject to complete successfully this requirement.~~

R4-30-262. Assayer-in-training ~~registration~~ Designation Requirements

A. No change
B. No change.
C. A candidate shall ~~take and pass~~ successfully complete the assayer-in-training examination administered and provided by the Board. ~~A candidate shall receive a minimum score of 70% as established by the Board on the examination to complete successfully this requirement.~~

R4-30-264. Assayer Registration Requirements

A candidate shall ~~take and pass~~ successfully complete the professional assayer examination administered and provided by the Board. ~~A candidate shall receive a minimum score of 70% as established by the board on the examination to complete successfully this requirement.~~

R4-30-282. Land Surveyor-in-training ~~registration~~ Designation Requirements

A. No change
B. No change.
C. The candidate shall ~~take and pass~~ successfully complete the land surveyor-in-training examination ~~administered~~ designated by the Board and provided by the National Council of ~~Engineering Examiners~~ Examiners for Engineers and Surveyors. ~~A candidate shall receive a minimum score of 70% as established by the Board to complete successfully this requirement.~~

R4-30-284. Land Surveyor Registration Requirements

The candidate shall ~~take and pass~~ successfully complete the professional land surveyor examination. Part One of the professional examination is ~~administered~~ designated by the Board and provided by the National Council of ~~Engineering and Surveying~~ Examiners for Engineers and Surveyors. Part Two of the professional examination is ~~administered~~ designated and provided by the Board. A candidate shall receive a minimum score of 70% as established by the Board on each part of the examination to complete successfully this requirement.

ARTICLE 3. REGULATORY PROVISIONS

R4-30-301. Rules of Professional Conduct

~~A.~~ A registrant shall comply with the following standards of professional conduct:
1. A registrant shall not submit any materially false statements or fail to disclose any material facts requested in connection with an application for registration or subpoena.
2. No change.
3. A registrant shall not sign, stamp or seal any plans, drawings, prints, land surveys, reports, specifications, or other documents not prepared by the registrant or his bona fide employee. Documents prepared by an Arizona registrant or registrant from another jurisdiction may be sealed by a second registrant providing the second registrant has conducted a complete review, made all the necessary changes to meet local conditions, and is an Arizona registrant. The initial registrant shall approve the second registrant's use of the documents by sealing and signing a written approval on all documents. In addition, the second registrant shall seal all documents. The second registrant shall be fully responsible for all documents.
4. No change.
5. No change.
6. No change.
7. No change.
8. No change.
9. No change.
10. No change.
11. No change.
12. No change.
13. No change.
14. No change.
15. No change.
16. No change.
17. No change.
18. A registrant who is designated as a responsible registrant shall be responsible for the firm or corporation's compliance with the Board statutes and rules, and shall be responsible for non-registrant employees' compliance with Board statutes and rules in the performance of the nonregistrant employee's duties for the firm or corporation. The Board may impose disciplinary action on the responsible registrant for any violation of Board statutes of rules that are committed by the non-registrant employee, or firm or corporation.
19. A registrant shall comply with any subpoena issued by the Board or its designated hearing officer.

~~B. A violation of any provision of this Section constitutes evidence of gross negligence, misconduct or professional incompetence.~~

R4-30-304. Use of Seals

A. A permanently legible imprint of the registrant's seal and signature shall appear on the following:
1. On each sheet of drawings or maps~~, when several master sheets are reproduced into a single set of finished drawings or maps, on each of the master sheets~~;
2. When master sheets are reproduced into a single set of finished drawings or maps, on each of the master sheets;

~~2.~~3. No change.
~~3.~~4. No change.
~~4.~~5. No change.
~~5.~~6. No change.
~~6.~~7. No change.

B. No change.
C. If a document, drawing, map, calculation, or other professional document is stored, filed, or provided to a client, regulatory body or any other person for any reason by computer disk, tape, cd, or any other electronic form, the registrant shall mark each document, drawing, map, calculation, or other professional document "electronic copy of final document, original sealed document with undersigned registrant."
D. A registrant shall sign, date and seal a professional document before the document is submitted to a client, contractor, any regulatory or review body, or any other person, unless the document is marked "preliminary" or "preliminary, not for construction."

~~D.~~E. For purpose of subsection A, all original documents shall:
1. Include an original seal imprint or computer generated seal which matches the seal on file at the Board office;
2. Include an original signature that does not ~~in any way~~ obscure both the registrant's printed name ~~or~~ and registration number; ~~or~~ and
3. Include in handwriting, the date the document was sealed.

~~E.~~F. Methods of transferring a seal other than an original seal imprint or a computer generated seal are not acceptable.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES OCCUPATIONAL LICENSING

PREAMBLE

1. **Sections Affected**

Sections Affected	Rulemaking Action
Article 2	New Article
R9-16-201	New Section
R9-16-202	New Section
R9-16-203	New Section
R9-16-204	New Section
R9-16-205	New Section
R9-16-206	New Section
R9-16-207	New Section
R9-16-208	New Section
R9-16-209	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-136(F)

   Implementing statute: A.R.S. §§ 36-901 through 36-1904.03

3. **A list of all previous notices appearing in the Register addressing the proposed rule:**

   Notice of Rulemaking Docket Opening: 4 A.A.R. 874-875, April 10, 1998.

4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Shirley Lockett, Program Manager

   Address: Department of Health Services
   Assurance & Licensure Services
   1647 East Morten, Suite 150
   Phoenix, Arizona 85020

   Telephone: (602) 674-4340

   Fax: (602) 861-0463

   Or

   Name: Kathleen Phillips, Rules Administrator
   Department of Health Services
   1740 West Adams, Room 410
   Phoenix, Arizona 85007

   Telephone: (602) 542-1264

   Fax: (602) 542-1289

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The rules are being proposed to implement A.R.S. §§ 36-1901 through 36-1940.03, which require the licensure and regulation of audiologists and speech-language pathologists by the Department of Health Services (Department).

   The rules set forth definitions and prescribe standards for qualifications for licensure, license applications, time-frames for approving or denying a license, clinical fellowship supervisors, license renewal, continuing education, disciplinary actions, equipment used in the practice of audiology or speech-language pathology, record keeping, and inspections.

   The Department did not rely on any study to evaluate or justify the rule.

6. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
   Not applicable.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

8. **The preliminary summary of the economic, small business, and consumer impact:**
   There will be some costs associated with the implementation of A.R.S. §§ 36-1901 through 36-1940.03, which require the Department to license and regulate individuals who practice audiology or speech-language pathology. The Department will incur costs associated with the production and review of applications, the approval of continuing education (CE) courses, and inspections. An individual practicing audiology or speech-language pathology is required to pay a $50 original license application fee, $50 licensure fee, $50 license renewal fee; obtain a minimum of 8 hours of CE per licensure year; and maintain records of CE courses attended, equipment maintained, services provided, and products dispensed.

   These costs are offset by the benefits that consumers will realize as a result of the proposed rules. Currently there are no protections for consumers who receive audiology or speech-language pathology services. The proposed rules establish minimum licensure and operational standards that reduce the possibility of physical, mental, emotional, and psychological harm to a consumer due to a misdiagnosis, or the improper or inadequate delivery of audiology or speech-language pathology services. In addition, the requirements for CE will provide increased opportunities for an individual who presents and receives payment for audiology or speech-language pathology CE courses by increasing the number of individuals attending audiology and speech-language pathology CE courses.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name:	Shirley Lockett, Program Manager
Address:	Department of Health Services Assurance & Licensure Services 1647 East Morten, Suite 150 Phoenix, Arizona 85020
Telephone:	(602) 674-4340
Fax:	(602) 861-0463
	Or
Name:	Kathleen Phillips, Rules Administrator Department of Health Services 1740 West Adams, Room 410 Phoenix, Arizona 85007
Telephone:	(602) 542-1264
Fax:	(602) 542-1289

10. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**
    A person may submit written comments on the proposed rules or economic impact statement by submitting the comments to the persons specified in paragraph 4 no later than the close of record, which is scheduled for Friday, December 4, 1998, at 5 p.m. The Department has scheduled the following oral proceedings:

Date:	November 30, 1998
Time:	10 a.m.
Location:	400 West Congress, Room 222 Tucson, Arizona 85701
Date:	December 2, 1998
Time:	1 p.m.
Location:	Flagstaff City-Coconino County Public Library 300 West Aspen Flagstaff, Arizona 86001
Date:	December 4, 1998
Time:	9 a.m.

Location: 1647 East Morten Avenue, Training Room
Phoenix, Arizona 85020

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None.

12. Incorporations by reference and their location in the rules:
American National Standard - Specification for Audiometers, S3.6-1996, Standards Secretariat, c/o Acoustical Society of America, 120 Wall Street, 32nd Floor, New York, New York, 10005-3993, January 12, 1996, at R9-16-209(B)(1).

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES
OCCUPATIONAL LICENSING

ARTICLE 2. LICENSING AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

Section
R9-16-201. Definitions
R9-16-202. Qualifications for Licensure
R9-16-203. License Application
R9-16-204. License Application Time Frames
R9-16-205. Clinical Fellowship Supervisors
R9-16-206. License Renewal
R9-16-207. Continuing Education
R9-16-208. Disciplinary Actions
R9-16-209. Equipment; Records; Inspections

ARTICLE 2. LICENSING AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

R9-16-201. Definitions
The following definitions apply in this Article, unless otherwise specified:

1. "Accredited" means approved by the:
   a. New England Association of Schools and Colleges,
   b. Middle States Association of Colleges and Secondary Schools,
   c. North Central Association of Colleges and Schools,
   d. Northwest Association of Schools and Colleges,
   e. Southern Association of Colleges and Schools, or
   f. Western Association of Schools and Colleges.
2. "Applicant" means an individual who submits to the Department an initial or a renewal application packet to practice audiology or speech-language pathology in Arizona.
3. "Application packet" means the information, documents, and fees required by the Department for licensure.
4. "Audiology" means the same as the definition in A.R.S. § 36-1901(2).
5. "ASHA" means the American Speech-Language-Hearing Association, a national scientific and professional organization for audiologists and speech-language pathologists.
6. "CCC" means Certificate of Clinical Competence, an award issued by ASHA to an individual who:
   a. Completes a graduate level degree in audiology or speech-language pathology from an accredited college or university that includes a clinical practicum;
   b. Passes the ETSNESPA; and
   c. Completes a clinical fellowship.
7. "CE" means continuing education, the ongoing process of receiving audiology or speech-language pathology-related courses.
8. "Clinical fellow" means an individual engaged in clinical fellowship.
9. "Clinical fellowship" means the postgraduate professional experience acquired by an individual, after completion of graduate level academic course work and a clinical practicum, during which the individual, while supervised by a clinical fellowship supervisor, is employed full-time or on a part-time equivalent basis to provide assessment, diagnosis, evaluation, screening, treatment, report writing, and counseling of individuals exhibiting speech, language, hearing, or communication disorders.
10. "Clinical fellowship agreement" means the document submitted to ASHA to register the initiation of a clinical fellowship.
11. "Clinical fellowship report" means a document completed by a clinical fellowship supervisor containing:
    a. A summary of a clinical fellow's diagnostic and therapeutic procedures,
    b. A verification of the clinical fellow's diagnostic and therapeutic procedures by the clinical fellowship supervisor, and
    c. An evaluation of the clinical fellow's procedures to perform the diagnostic and therapeutic procedures.
12. "Clinical practicum" means the graduate level experience acquired by an individual completing course work in audiology or speech-language pathology during which the individual, while supervised by an individual holding a CCC, provides assessment, diagnosis, evaluation, screening, treatment, and counseling to individuals exhibiting speech, language, hearing, or communication disorders.
13. "Clinical fellowship supervisor" means an audiologist or speech-language pathologist who:
    a. Had a CCC while supervising a clinical fellow before the effective date of this Article or in another state; or
    b. Has a current license and supervises a temporary licensee.
14. "Course" means a workshop, seminar, lecture, conference, class, or instruction.
15. "Days" means calendar days.
16. "Diagnostic and therapeutic procedures" means the principles and methods used by an audiologist in the practice of audiology or a speech-language pathologist in the practice of speech-language pathology.

17. "Disciplinary action" means a proceeding that is brought against a licensee by the Department under A.R.S. § 36-1934 or a state licensing agency or board.
18. "ETSNESPA" means Educational Testing Service National Examination in Speech-Language Pathology and Audiology, the specialty area test of the Praxix Series given by the Education Testing Service, Princeton, N.J.
19. "Full-time" means 30 clock hours or more per week.
20. "Graduate level" means the status of a master's or doctoral degree.
21. "License" means the written authorization issued by the Department to practice audiology or speech-language pathology.
22. "Local education agency" means a school district governing board established by A.R.S. §§ 15-301 through 15-396.
23. "Monitor" means to be responsible for and provide direction to a clinical fellow without directly observing diagnostic and therapeutic procedures.
24. "On-site observations" means the presence of a clinical fellowship supervisor who is watching a clinical fellow perform diagnostic and therapeutic procedures.
25. "Part-time equivalent" means:
    a. 25-29 clock hours per week for 48 weeks,
    b. 20-24 clock hours per week for 60 weeks, or
    c. 15-19 clock hours per week for 72 weeks.
26. "Pupil" means a child attending a school, a private school, or an accommodation school, which are defined in A.R.S. § 15-101.
27. "Semester credit hour" means 1 earned academic unit of study based on completing, at an accredited college or university, a 50 or 60 minute class session per calendar week for 15 to 18 weeks.
28. "Semester credit hour equivalent" means 1 quarter credit is equal in value to 2/3 of a semester credit hour.
29. "Speech-language pathology" means the same as the definition in A.R.S. § 36-1901(17).
30. "State supported institution" means a school receiving funding under A.R.S. §§ 15-901 through 15-1086.
31. "Supervise" means to be responsible for and provide direction to:
    a. A clinical fellow during on-site observation or monitoring of the clinical fellow's diagnostic and therapeutic procedures; or
    b. An individual completing a clinical practicum.
32. "Supervisory activities" means evaluations and assessments of a clinical fellow's diagnostic and therapeutic procedures in providing assessment, diagnosis, evaluation, screening, treatment, and counseling to individuals exhibiting speech, language, hearing, or communication disorders.
33. "Week" means the period of time beginning at 12:00 a.m. on Sunday and ending at 11:59 p.m. the following Saturday.

R9-16-202. Qualifications for Licensure

An applicant shall meet the requirements set forth in A.R.S. § 36-1940 to qualify for an audiologist's license or A.R.S. § 36-1940.01 to qualify for a speech-language pathologist's license.

1. To demonstrate that an applicant has obtained an equivalent to a master's degree in audiology as stated in A.R.S. § 36-1940(A)(2)(a), (B)(2)(a) or speech-language pathology as stated in A.R.S. § 36-1940.01(A)(2)(a), the applicant shall provide the Department with written documentation of completing a minimum of 60 semester credit hours or semester credit hour equivalent in audiology or speech-language pathology from an accredited college or university.
    a. To qualify for an audiologist's license, the applicant shall complete a minimum of 24 graduate level semester credit hours in the area of audiology and a minimum of 6 graduate level semester credit hours in the area of speech-language pathology.
    b. To qualify for a speech-language pathologist's license, the applicant shall complete a minimum of 24 graduate level semester credit hours in the area of speech-language pathology and a minimum of 6 graduate level semester credit hours in the area of audiology.
    c. An applicant is allowed no more than 6 graduate level semester credit hours for the clinical practicum.
    d. The Department shall not permit semester credit hours for a thesis or dissertation to be used to meet the requirements of this subsection.
2. To demonstrate that an applicant has completed a clinical practicum in audiology as required in A.R.S. § 36-1940(A)(2)(b), (B)(2)(b) or speech-language pathology as required in A.R.S. § 36-1940.01(A)(2)(b), the applicant shall provide the Department with written documentation of completing a minimum of 300 clock hours in a clinical practicum at an accredited college or university.
    a. An individual applying for an audiologist's license shall complete 200 clock hours or more in audiology. Of the 200 clock hours:
        i. Fifty clock hours shall be in auditory assessment,
        ii. Fifty clock hours shall be in habilitation and rehabilitation, and
        iii. Thirty-five clock hours shall be in speech-language pathology.
    b. An individual applying for a speech-language pathologist's license shall complete 200 clock hours or more in speech-language pathology. Of the 200 clock hours:
        i. Seventy-five clock hours shall be in language,
        ii. Twenty-five clock hours shall be in fluency,
        iii. Twenty-five clock hours shall be in voice, and
        iv. Thirty-five clock hours shall be in hearing disorders.
3. To demonstrate that an applicant has completed the postgraduate professional experience required by A.R.S. § 36-1940(A)(2)(c), (B)(2)(c), or A.R.S. § 36-1940.01(A)(2)(c), the applicant shall provide the Department with written documentation of completing 36 weeks or more of a clinical fellowship.
    a. The clinical fellowship shall be completed within 7 years from the date the clinical practicum was completed;
    b. Once initiated, the clinical fellowship shall be completed in no more than 36 consecutive months; and
    c. A minimum of 80% of the clinical fellowship hours shall be in direct client contact.

R9-16-203. License Application

A. An applicant for a regular audiology license or a regular speech-language pathology license shall submit to the Department an application packet containing:

1. An application on a form provided by the Department and signed by the applicant that contains all of the following:
   a. The applicant's name, current home address, business address, and home and business telephone numbers;
   b. If applicable, the name of applicant's employer, employer's current business address and telephone number;
   c. A statement of whether the applicant has ever been convicted of a felony or a misdemeanor involving moral turpitude in this state or any other state;
   d. A listing of all states and countries in which the applicant is or has been licensed;
   e. A statement of whether any disciplinary action, consent order, or settlement agreement is pending or has been imposed by any state or country upon the applicant's audiology or speech-language pathology license; and
   f. A statement by the applicant verifying the truthfulness of the information provided by the applicant;
2. An official transcript issued to the applicant by an accredited college or university after the applicant's completion of a master's degree or 30 graduate level semester hours as provided in R9-16-202(1);
3. Written documentation of the applicant's completion of a clinical practicum as required by R9-16-202(2) or a copy of a current CCC;
4. A photocopy of the clinical fellowship report signed by the clinical fellowship supervisor as required by R9-16-202(3) or a copy of a current CCC;
5. Written documentation of a passing grade on the ETSNESPA or a copy of a current CCC; and
6. An application fee of $50.

B. An applicant for a temporary license shall submit to the Department an application packet containing:
   1. An application on a form provided by the Department containing the information in subsections (A)(1), (A)(2), (A)(3), and (A)(5);
   2. A copy of the clinical fellowship agreement that includes:
      a. The clinical fellow's name, home address, and telephone number;
      b. The clinical fellowship supervisor's name, business address, telephone number, and Arizona audiology or speech-language pathology license number;
      c. The name of and address where the clinical fellowship will take place;
      d. A statement by the clinical fellowship supervisor agreeing to conform to the rules in R9-16-205;
      e. The signatures of the clinical fellow and the clinical fellowship supervisor; and
   3. An application fee of $50.

C. An applicant for an audiology license to fit and dispense hearing aids shall submit to the Department an application packet containing:
   1. The information, documents, and fee required in subsection(A); and
   2. Written documentation of passing a hearing aid dispenser examination as required by A.R.S. § 36-1940(B)(4).

D. An applicant for a speech-language pathology license limited to providing services to pupils under the authority of a local education agency or state supported institution shall submit to the Department an application packet containing:
   1. An application on a form provided by the Department containing the information in subsection (A)(1);
   2. A copy of a temporary or standard certificate in speech-language therapy issued by the State Board of Education;
   3. A copy of a contract of certificated employment with a local education agency or state supported institution that includes:
      a. The applicant's name and social security number,
      b. The name of the local education agency or state supported institution,
      c. The classification title of the applicant,
      d. The work dates of the contract of employment, and
      e. Signatures of the applicant and the individual authorized by the governing board to represent the local education agency or state supported institution; and
   4. An application fee of $50.

R9-16-204. License Application Time-frames

A. For any of the license applications in R9-16-203 or R9-16-206, the overall time-frame described in A.R.S. § 41-1072(2) is 45 days.

B. For any of the license applications in R9-16-203 or R9-16-206, the administrative completeness review time-frame is 30 days and begins on the date the Department receives an application packet.
   1. If an application packet is incomplete, the Department shall send to the applicant a written notice of incompleteness that states each deficiency and the information or documents needed to complete the application packet. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives a complete application packet.
   2. When the Department receives a complete application packet, the Department shall send a written notice of administrative completeness to the applicant.
   3. If the applicant does not supply a complete application packet within 360 days from the date the Department receives an application, the Department shall consider the application withdrawn.
   4. If the Department sends a written notice of approval to the applicant during the time provided to assess administrative completeness, the Department shall not provide a separate written notice of administrative completeness.

C. For any of the license applications in R9-16-203, the substantive review time-frame described in A.R.S. § 41-1072(3) is 15 days and begins on the date the Department sends written notice of administrative completeness to an applicant.
   1. If an applicant does not meet the requirements of A.R.S. §§ 36-1901 through 36-1940.03 and this Article, the Department shall send a written notice of denial to the applicant including a basis for the denial and an explanation of the applicant's right to appeal.
   2. If an applicant meets the requirements of A.R.S. §§ 36-1901 through 36-1940.03 and this Article, the Department shall send written notice of approval to the applicant.

D. After receiving the written notice of approval in subsection (C)(2), an applicant shall send a $50 license fee to the Department.

R9-16-205. Clinical Fellowship Supervisors

In addition to complying with the requirements in A.R.S. § 36-1905, a clinical fellowship supervisor shall:

1. Complete a minimum of 36 supervisory activities throughout a clinical fellowship. Of the 36 supervisory activities, the clinical fellowship supervisor shall complete:
   a. A minimum of 18 on-site observations;
   b. No more than 6 on-site observations in 24 hours; and
   c. A minimum of 18 monitoring activities;
2. Submit a copy of the clinical fellowship report to the Department within 30 days of the completion of the clinical fellowship; and
3. No later than 72 hours after terminating a clinical fellowship, provide the Department and the clinical fellow with written notice of the termination.

R9-16-206. License Renewal

A. Before the expiration date of a regular license, a licensee shall submit to the Department an application packet containing:
   1. A license renewal fee of $50;
   2. A completed record of compliance with the CE requirements in R9-16-207; and
   3. A license renewal form provided by the Department that contains:
      a. The licensee's name, current home address, business address, and home and business telephone numbers;
      b. If applicable, the name of the licensee's employer, employer's current business address, and telephone number;
      c. License number and date of expiration; and
      d. A statement of whether the licensee has ever been convicted of a felony or a misdemeanor involving moral turpitude.

B. A licensee who submits the information and fee in subsection (A)(1) no later than 30 days after the license expiration date shall submit a $10 late fee in addition to the information and fee required by subsection (A).

C. When renewing a temporary license, the licensee shall submit a license renewal fee of $50 and a form provided by the Department containing:
   1. The applicant's name, address, and phone number;
   2. The name of applicant's employer, employer's current business address, telephone number, and Arizona audiologist or speech-language pathologist license number;
   3. The clinical fellowship supervisor's name, business address, telephone number, and Arizona audiologist or speech-language pathologist license number;
   4. A statement by the clinical fellowship supervisor agreeing to conform to the rules in R9-16-205; and
   5. The signature of the clinical fellowship supervisor.

R9-16-207. Continuing Education

A. Every 12 months from the effective date of a regular license, a licensee shall complete 8 credit hours or more of CE approved by the Department. A credit hour shall consist of a minimum of 50 continuous minutes of instruction.

B. An individual presenting a CE course or a licensee requesting approval for a CE course shall submit the following to the Department:
   1. A brief summary of the course;
   2. The name, educational background, and teaching experience of the individual presenting the course;
   3. The educational objectives of the course;
   4. The name of the organization providing the CE course; and
   5. The date, time, and place of presentation of the CE course.

C. If a licensee submits the information in subsection (B) with an application packet, the Department shall comply with the time-frames in R9-16-204.

D. For Department approval of a CE course, the overall time-frame described in A.R.S. § 41-1072(2) is 45 days.

E. For Department approval of a CE course, the administrative completeness review time-frame is 30 days and begins on the date the Department receives a request for CE approval.
   1. If a request for CE approval is incomplete, the Department shall send to an individual presenting a CE course or a licensee, a written notice of incompleteness that states each deficiency and the information or documents needed to complete the request. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives a complete request for CE approval.
   2. When the Department receives a complete request for CE approval, the Department shall send a written notice of administrative completeness to the individual presenting a CE course or a licensee.
   3. If the individual presenting a CE course or a licensee does not supply a complete request for CE approval within 60 days from the date the Department receives a request for CE approval, the Department shall consider the request for CE approval withdrawn.
   4. If the Department grants approval for a CE course during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

F. For Department approval of a CE course, the substantive review time-frame described in A.R.S. § 41-1072(3) is 15 days and begins on the date the Department sends written notice of administrative completeness to an individual presenting the CE course or a licensee.
   1. If a CE course does not meet the requirements in subsection (G), the Department shall send a written notice of denial to the individual presenting the CE course or the licensee including a basis for the denial.
   2. If a CE course meets the requirements of subsection (G), the Department shall send written notice of approval to the individual presenting the CE course or the licensee.

G. The Department shall approve a CE course if the Department determines that the CE course:
   1. Is designed to provide current developments, skills, procedures, or treatment in diagnostic and therapeutic procedures in audiology or speech-language pathology;
   2. Is developed and presented by individuals knowledgeable and experienced in the subject area; and
   3. Contributes directly to the professional competence of a licensee.

H. A licensee shall maintain a record of each CE course completed by the licensee for 36 months from the date of submitting the record to the Department as required by R9-16-206(A)(2). The record shall contain:
   1. The name, address, and license number of the licensee;
   2. For each CE course completed by the licensee:
      a. The name of the organization providing the CE course, and the date and place of presentation;
      b. The name of the CE course;

c. A description of the CE course's content and educational objectives;
d. The name and description of the educational background and teaching experience of the individual presenting each course;
e. The number of CE credit hours earned for the CE course; and
f. A statement, signed by the individual presenting the CE course, verifying the licensee's attendance; and

3. A statement, signed by the licensee, verifying the information contained in the record.

I. A licensee is not permitted to carry forward CE credit hours from a previous year.

R9-16-208. Disciplinary Actions

In determining the length of license suspension or revocation, or the level of disciplinary action for any violation of A.R.S. §§ 36-1901 through 36-1940.03 or this Article, the Department shall consider:

1. The type of violation,
2. The severity of the violation,
3. The danger to the public health and safety,
4. The number of violations,
5. The degree of harm to the consumer,
6. Pattern of non-compliance, and
7. Any mitigating or aggravating circumstances.

R9-16-209. Equipment; Records; Inspections

A. A licensee shall maintain equipment used by the licensee in the practice of audiology or the practice of speech-language pathology according to the manufacturer's specifications.

B. If a licensee uses equipment that requires calibration, the licensee shall ensure that:
1. The equipment is calibrated a minimum of every 12 months according to the American National Standard - Specifications for Audiometers, S3.6-1996, Standards Secretariat, c/o Acoustical Society of America, 120 Wall Street, 32nd Floor, New York, New York 10005-3993, January 12, 1996, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments; and
2. A written record of the calibration is maintained in the same location as the calibrated equipment for 36 months from the date of the calibration.

C. A licensee shall maintain the following records for 36 months from the date the licensee provided a service or dispensed a product while engaged in the practice of audiology, practice of speech-language pathology, or practice of fitting and dispensing hearing aids:
1. The name, address, and telephone number of the individual to whom services are provided;
2. The name or description and the results of each test and procedure used in evaluating speech, language, and hearing disorders or determining the need for dispensing a product or service; and
3. If a product such as a hearing aid, augmentative communication device, or alaryngeal device is dispensed, a record of the following:
a. The name of the product dispensed;
b. The product's serial number, if any;
c. The product's warranty or guarantee, if any;
d. The refund policy for the product, if any;
e. A statement of whether the product is new or used;
f. The total amount charged for the product;
g. The name of the licensee; and
h. The name of the intended user of the product.

D. A licensee shall permit the Department to inspect the equipment in subsection (A) and the records listed in subsections (B) and (C).

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1.

Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-106	Repeal
R9-22-106	New Section
Article 6	Repeal
Article 6	New Article
R9-22-601	Repeal
R9-22-601	New Section
R9-22-602	Repeal
R9-22-602	New Section
R9-22-603	Repeal
R9-22-603	New Section
R9-22-604	Repeal
R9-22-604	New Section
R9-22-605	Repeal

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 36-2903.01(H)

~~or award does not comply with procurement statues and rules, remedies shall be implemented pursuant to subsection (F) of this Section.~~

~~L. Hearing procedures.~~

~~1. If a hearing is required or permitted under this Section, the Director shall appoint a hearing officer.~~

~~2. If a hearing is required or permitted the hearing officer shall arrange for a prompt hearing and notify the parties in writing of the time and place of the hearing.~~

~~3. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.~~

~~4. The hearing officer may:~~

~~a. Hold pre-hearing conferences to settle, simplify, or identify the issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;~~

~~b. Require parties to state their positions concerning the various issues in the proceeding;~~

~~c. Require parties to produce for examination those relevant witnesses and documents under their control;~~

~~d. Rule on motions and other procedural items on matters pending before such officer;~~

~~e. Regulate the course of the hearing and conduct of participants;~~

~~f. Establish time limits for submission of motions or memoranda;~~

~~g. Impose appropriate sanctions against any person failing to obey an order under these procedures, which may include:~~

~~i. Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;~~

~~ii. Excluding all testimony of an unresponsive or evasive witness; and~~

~~iii. Expelling the person from further participation in the hearing;~~

~~h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matters of judicial notice; and~~

~~i. Administer oaths or affirmations.~~

~~5. A transcribed record of the hearing shall be made available at cost to the requesting party.~~

~~M. Recommendation by the hearing officer.~~

~~1. The hearing officer shall make a recommendation to the Director based on the evidence presented. The recommendation shall include findings of fact and conclusions of law.~~

~~2. The Director may affirm, modify, or reject the hearing officer's recommendation in whole or in part, may remand the matter to the hearing officer with instructions, or make any other appropriate disposition.~~

~~N. Final decision by the Director. A decision by the Director shall be final. The decision shall be sent to all parties by personal service or certified mail, return receipt requested. The decision shall state that any party adversely affected may within ten days of receipt request a rehearing.~~

~~O. Rehearing of Director's decision.~~

~~1. Any party, including a procurement officer, who is aggrieved by the Director's decision may file a written request for rehearing of the decision specifying the particular grounds.~~

~~a. The request for rehearing shall be filed with the Director within ten days after receipt of the decision.~~

~~b. The request shall be clearly designated as a "Request for Rehearing".~~

~~2. The Director or hearing officer may require the filing of written briefs and may provide for oral argument.~~

~~3. A rehearing of the decision may be granted for any of the following causes:~~

~~a. Irregularity in the proceedings or an abuse of discretion by the Director depriving the requesting party of a fair hearing;~~

~~b. Misconduct of the Director, his staff or the hearing officer or any party;~~

~~c. Accident or surprise that could not have been prevented by ordinary prudence;~~

~~d. Newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original hearing;~~

~~e. Excessive or insufficient penalties;~~

~~f. Error in the admission or rejection of evidence or other error of law occurring at the hearing;~~

~~g. A showing that the decision is not justified by the evidence or is contract to law.~~

~~4. The Director's decision concerning a request for rehearing shall be in writing and shall state the basis of the decision. A decision granting a rehearing shall specify with particularity the grounds on which the rehearing is granted, and the date, time and place of the rehearing. The rehearing shall cover only those matters specified in the decision.~~

~~5. The Director, within the time for filing a request for rehearing under this subsection, may on his own initiative order a rehearing of his decision for any reason for which he might have granted a rehearing on request of a party.~~

~~P. Failure to exhaust administrative remedies. Failure to submit a protest and appeal in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking a judicial review.~~

ARTICLE 6. REQUEST FOR PROPOSALS (RFP)

R9-22-601. General Provisions

A. This Article applies to the expenditure of all public monies by the Administration for covered services under 9 A.A.C. 22, Article 2 and 9 A.A.C. 22, Article 12 except as otherwise provided by law. The Administration shall ensure that it has in effect conflict of interest safeguards with respect to officers and employees of the state with responsibilities relating to contracts as specified in 42 U.S.C. 1396u-2, August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. If it is deemed by the Director to be in the best interest of the state, the Director may cancel a RFP or reject any and all proposals, in whole or in part, as specified in the RFP. The reasons for cancellation or rejection shall be part of the contract file.

C. The Director may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors and affiliated corporate organizations of an offeror.

D. Proposals may be opened publicly and the name of each offeror announced and recorded. All other information contained in the proposals shall be confidential. The proposals

shall be open for public inspection after contract award unless, upon an offeror's written request for non-disclosure, the Director determines that disclosure is not in the best interest of the state.

E. Failure by an offeror to supply satisfactory information as requested by the Administration is sufficient basis for the rejection, by the Administration, of any proposal.

F. Disclosure by an offeror of the terms of its proposal to another offeror or to any other person prior to contract award is prohibited and may be grounds for rejecting a proposal.

R9-22-602. Request for Proposals (RFP); Contract Award

A. RFP content. The following items shall be included in a RFP:
   1. The instructions and information to an offeror concerning the proposal submission requirements, including:
      a. The deadline for submitting a proposal,
      b. The address of the office at which a proposal is to be received,
      c. The period during which the proposal shall remain open, and
      d. Any other special instructions and information;
   2. The service description, covered populations, geographic coverage, and a delivery or performance schedule;
   3. The contract terms and conditions, including bonding or other security requirements, if applicable;
   4. The factors to be used in the evaluation;
   5. The location of and method for obtaining documents that are incorporated by reference;
   6. A requirement that the offeror acknowledge receipt of all amendments issued by the Administration;
   7. The type of contract to be used and a copy of a proposed contract form or provisions;
   8. The estimated length of time during which service shall be required;
   9. A requirement for cost or pricing data;
   10. The minimum information that the proposal shall contain; and
   11. A provision requiring that an offeror certify that the submission of the proposal does not involve collusion or other anti-competitive practices.

B. Evaluation of a proposal.
   1. The Administration shall evaluate a proposal based on the evaluation factors listed in the RFP.
   2. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. When having discussions, the Administration shall not disclose any information derived from a proposal submitted by a competing offeror.
   3. The Administration may issue a written request for best and final offers. The request shall state the date, time, and place for the submission of best and final offers.
   4. Best and final offers may be requested only once unless the Director determines that it is advantageous to the state to request additional best and final offers. The written request for best and final offers shall inform the offeror that if the offeror does not submit a notice of withdrawal or a best and final offer, the immediate previous offer shall be construed as the offeror's best and final offer.
   5. The Director shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be made part of the contract file and public record.

C. Contract award. The Director shall award the contract to the responsible and responsive offeror whose proposal is deemed most advantageous to the state. If the Director determines that multiple contracts are in the best interest of the state, the Director may award multiple contracts. The contract file shall contain the basis on which the award is made.

R9-22-603. Contract Records

All contract records shall be retained for a period of 5 years and disposed of under A.R.S. § 41-2550.

R9-22-604. Contract or Proposal Protests; Appeals

A. Grievances related to contract performance. This Section shall not apply to grievances related to contract performance. Any contract performance grievance shall be governed by R9-22-804.

B. Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.

C. Filing of a protest.
   1. An interested party may file a protest with the procurement officer regarding:
      a. A RFP issued by the Administration;
      b. A proposed award; or
      c. An award of a contract.
   2. The protest shall be in writing and shall include the following information:
      a. The name, address, and telephone number of the protester;
      b. The signature of the protester or its representative;
      c. Identification of a RFP or contract number;
      d. A detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and
      e. The relief requested.

D. Time for filing a protest.
   1. An interested party may file a protest based on alleged improprieties in a RFP before the closing date for receipt of initial proposals.
   2. A protest alleging improprieties that do not exist in an initial RFP but are subsequently incorporated into the RFP prior to the receipt of initial proposals shall be filed prior to the closing date for receipt of initial proposals.
   3. In cases other than those covered in subsection (D)(1) and (D)(2), a protest shall be filed within 10 days after the protester knows or should have known the basis of the protest.

E. Stay of procurements during the protest. If a protest is filed before the contract award, the procurement officer may issue a written stay of the contract award if:
   1. There is a reasonable probability that the protest will be sustained, and
   2. The stay of the contract award is not contrary to the best interest of the state.

F. Decision by the procurement officer.
   1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
   2. The procurement officer shall furnish a copy of the decision to the protester by:
      a. Certified mail, return receipt requested; or
      b. Any other method that provides evidence of receipt.

3. The Director may extend, for good cause, the time-limit for decisions in subsection (F)(1) for a reasonable time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision will be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (F)(1) or (F)(3) the protester may proceed as if the procurement officer issued an adverse decision.

G. Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall implement an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances surrounding the procurement or proposed procurement including but not limited to the:
   a. Seriousness of the procurement deficiency,
   b. Degree of prejudice to other interested parties or to the integrity of the procurement system,
   c. Good faith of the parties,
   d. Extent of performance,
   e. Costs to the government,
   f. Urgency of the procurement, and
   g. Impact of the relief on the Administration's mission.
3. An appropriate remedy may include 1 or more of the following:
   a. Terminate the contract;
   b. Reissue the RFP;
   c. Issue a new RFP;
   d. Award a contract consistent with procurement statutes and rules; or
   e. Other relief as is determined necessary to ensure compliance with applicable statutes and regulations.

H. Appeals to the Director.
1. The appellant shall file an appeal from a decision by the procurement officer with the Director within 5 days from the date the decision is received. The appellant shall also file a copy of the appeal with the procurement officer.
2. The appeal shall contain:
   a. The information required in subsection (C)(2),
   b. A copy of the decision of the procurement officer,
   c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
   d. A request for hearing unless the appellant desires that the Director's decision be based solely upon the contract record.

I. Stay of contract award during an appeal to the Director. If an appeal is filed before a contract award and the contract award was stayed by the procurement officer under subsection (E), the filing of an appeal to the Director shall automatically continue the stay unless the Director issues a written determination that the contract award is necessary to protect the best interest of the state.

J. Dismissal before hearing. The Director shall dismiss, with a written determination, an appeal before scheduling a hearing if:
1. The appeal does not state a valid basis for protest;
2. The appeal is untimely under subsection (H); or
3. The appeal is moot.

K. Hearing. Hearings requested under this rule shall be conducted under 9 A.A.C. 22, Article 8.

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, BANKING AND INSURANCE

CHAPTER 5. THE INDUSTRIAL COMMISSION OF ARIZONA

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**
   R20-5-507 — Amend

2. **The specific authority for the rulemaking, including both the authorizing statute(general) and the statutes the rules are implementing (specific):**
   Authorizing statute: A.R.S. § 23-491.04

   Implementing statute: A.R.S. § 23-491.06

3. **A list of all previous notices appearing in the Register addressing the final rule:**
   Notice of Rulemaking Docket Opening: 3 A.A.R. 3263, November 14, 1997.

4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Patrick Ryan, Assistant Director
Address	Division of Occupational Safety and Health Industrial Commission of Arizona 800 West Washington Street, Suite 203 Phoenix, Arizona 85007
Telephone:	(602) 542-1695
Fax:	(602) 542-1614

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**
The proposed rule will bring the state's rules for elevators and escalators into conformance with the technological advances currently being utilized by the industry. Because the national elevator and escalator manufacturers are currently producing elevators and escalators to meet the new ASME A17.1-1996 Safety Code for Elevators and Escalators, the Industrial Commission finds it necessary to update its rules to ensure that, once installed, these newer elevators and escalators will operate in accordance with the code which they were designed, manufactured, and installed to meet. Existing elevator and escalator installations are required to continue to meet the code requirements that were in effect at the time of installation.

6. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
Not applicable.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.

8. **The preliminary summary of the economic, small business, and consumer impact:**
By adopting and enforcing the ASME A17.1 1996 Safety Code for Elevators and Escalators The Industrial Commission of Arizona will require that elevators, escalators, and related equipment operate in the safe and beneficial manner for which they were designed, manufactured and installed. While there will be an initial period of instruction regarding the changes of this rule, these costs are expected to be minimal.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name:	Patrick Ryan
	Assistant Director
Address:	Industrial Commission of Arizona Division of Occupational Safety and Health 800 West Washington Street, Suite 203 Phoenix, Arizona 85007
Telephone:	(602) 542-1695
Fax:	(602) 542-1614

10. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**
An oral proceeding has been scheduled as follows:

Date:	December 3, 1998
Time:	9:30 a.m.
Location:	Industrial Commission of Arizona 3rd floor conference room 800 West Washington Street Phoenix, Arizona 85007
Nature:	A public hearing for the taking of oral or written testimony regarding the proposed rules.

Written comments may be submitted on or before 9:30 a.m., December 3, 1998.

11. **Any other matters prescribed by statue that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporation by reference and their location in the rules:**
ASME A17.1-1996 Safety Code for Elevators, The American Society of Mechanical Engineers, United Engineering Center, 345 East 47th Street, New York, NY. 10017.

13. **The full text of the rule follows:**

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 5. ELEVATOR SAFETY ADMINISTRATIVE REGULATIONS

Section

R20-5-507. Safety Code for Elevators, Escalators, Dumbwaiters, Moving Walks, Material Lifts and Dumbwaiters with Automatic Transfer Devices, Wheelchair

Lifts and Stairway Chairlifts.

R20-5-507. Safety Code for Elevators, Escalators, Dumbwaiters, Moving Walks, Material Lifts and Dumbwaiters with Automatic Transfer Devices, Wheelchair Lifts and Stairway Chairlifts.

A. Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift or dumbwaiter with an automatic transfer device, wheelchair lift, or stairway chairlift ~~chair lift~~ installed on or after the effective date of this rule shall comply with the ASME A17.1-1996 ~~A17.1-1993~~ Safety Code for Elevators and Escalators, incorporated by reference and on file with the Office of the Secretary of State. Every other owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, or dumbwaiter with an automatic transfer device, wheelchair lift, or stairway chairlift shall comply with the ASME A17.1 Safety Code for Elevators and Escalators in effect at the time of installation or, as an alternative, may comply with ASME A17.1-1996. ~~A17.1-1993.~~ A copy of this referenced material is also available for review at the Industrial Commission of Arizona and may be obtained from the American Society of Mechanical Engineers, United Engineering Center, 345 East 47th Street, New York, NY 10017. This incorporation by reference does not include amendments or editions to ASME A17.1 published after December 31, 1996. ~~1993.~~

B. No change.

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, BANKING AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. **Sections Affected**

Sections Affected	Rulemaking Action
R20-6-1102	Amend
R20-6-1102.01	New Section
R20-6-1106	Amend
R20-6-1108	Amend
R20-6-1113	Amend
R20-6-1121	New Section
Appendix B	Amend
Appendix F	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. §§20-143, 20-1133; 42 U.S.C. 1395

   Implementing statutes: A.R.S. §§ 20-142 and 20-143

3. **List of all previous notices appearing in the register addressing the proposed rule:**

   Notice of Docket Opening: 4 A.A.R. 3051 (October 16, 1998)

4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Vista Thompson Brown

   Address: Arizona Department of Insurance
   2910 N. 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8456

   Fax Number: (602) 912-8452

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The rule is necessary to conform Arizona's Medicare supplement insurance rules with the recently adopted federal regulations pertaining to Medicare+Choice.

6. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

   None.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   None.

8. **The preliminary summary of the economic, small business and consumer impact:**

   The Department does not anticipate that the rule changes will economically impact the Department.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business and consumer impact statement:**

Name:	Vista Thompson Brown
Address:	Arizona Department of Insurance 2910 N. 44th Street, Suite 210 Phoenix, Arizona 85018
Telephone:	(602) 912-8456
Fax:	(602) 912-8452

10. **The time, place and nature of the proceeding for the admission, amendment or repeal of the rule or, if no proceeding is scheduled, where, when and how persons may request an oral proceeding on the proposed rule:**

The Department invites and will accept written comment during regular business hours at the address listed in question #3 until the close of the record at 5:00 p.m. on December 4, 1998, concerning the Medicare supplemental insurance rules to be revised as a part of this rulemaking process.

An oral hearing will be held on December 3, 1998, at 2:00 p.m. at the Department of Insurance, 2910 N. 44th Street, Phoenix, Arizona, in the Third Floor Training Room.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

None.

12. **Incorporation by reference and their location in the rules:**

None.

13. **The full text of the rules follow:**

TITLE 20. COMMERCE, PROFESSIONS, AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section
R20-6-1102. Definitions
R20-6-1102.01. Creditable Coverage
R20-6-1106. Standard Medicare Supplement Benefit Plans
R20-6-1108. Open Enrollment
R20-6-1113. Required Disclosure Provisions
R20-6-1121. Guaranteed Issue for Eligible Persons
Appendix B. Medicare Supplement Coverage Plans
Appendix F. Medicare Duplication Disclosure Statements

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1102. Definitions

In this Article, the following definitions apply.

1. No change.
2. No change.
3. No change.
4. "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Arizona.
5. "Brackets" or "[ ]" means the amount or text within the brackets is subject to change or variation.

6.~~4.~~ No change.
7.~~5.~~ No change.
8.~~6.~~ No change.
9.~~7.~~ No change.
10.~~8.~~ No change.

11. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.
12. "Creditable coverage" means the type of insurance coverage described in R20-6-1102.01.
13. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act).

14.~~9.~~ No change.
15.~~10.~~ No change.

16. "Insolvency" means when an issuer, licensed to transact the business of insurance in Arizona, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

17.~~11.~~ No change.
18.~~12.~~ No change.

19. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:
    a. Coordinated care plans which provide health care services, including but not limited to health care services organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
    b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
    c. Medicare+Choice private fee-for-service plans.

20.~~13.~~ No change.
21.~~14.~~ No change.
22.~~15.~~ No change.
23.~~16.~~ No change.
24.~~17.~~ No change.
25.~~18.~~ No change.
26.~~19.~~ No change.

27. "Secretary" means the Secretary of the United States Department of Health and Human Services.

28. ~~20.~~ No change.

R20-6-1102.01. Creditable Coverage

A. Creditable coverage means, with respect to an individual, coverage of the individual provided under any of the following:
   1. A group health plan;
   2. Health insurance coverage;
   3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
   4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. § 1928;
   5. Chapter 55 of Title 10 United States Code (CHAMPUS);
   6. A medical care program of the Indian Health Service or of a tribal organization;
   7. A state health benefits risk pool;
   8. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
   9. A public health plan as defined in federal regulation; and
   10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C § 2504(e)).

B. Creditable coverage shall not include 1 or more, or any combination of, the following:
   1. Coverage only for accident or disability income insurance, or any combination thereof;
   2. Coverage issued as a supplement to liability insurance;
   3. Liability insurance, including general liability insurance and automobile liability insurance;
   4. Workers' compensation or similar insurance;
   5. Automobile medical payment insurance;
   6. Credit-only insurance;
   7. Coverage for on-site medical clinics; and
   8. Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

C. Creditable coverage shall not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:
   1. Limited scope dental or vision benefits;
   2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
   3. Such other similar, limited benefits as are specified in federal regulations.

D. Creditable coverage shall not include the following benefits if offered as independent, non-coordinated benefits:
   1. Coverage only for a specified disease or illness, and
   2. Hospital indemnity or other fixed indemnity insurance.

E. Creditable coverage shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:
   1. Medicare supplemental health insurance as defined under 42 U.S.C. § 1882(g)(1) of the Social Security Act;
   2. Coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (CHAMPUS); and
   3. Similar supplemental coverage provided to coverage under a group health plan.

R20-6-1106. Standard Medicare Supplement Benefit Plans

A. No change.
B. No change.
C. No change.
D. No change.
E. No change.
   1. No change.
   2. No change.
   3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (3), and ~~R20-6-1105(D)(1)~~(8) respectively.
   4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and at-home recovery benefits as described in R20-6-1105(D)(1), ~~and~~ (2), ~~R20-6-1105~~(8), and ~~R20-6-1105~~(10) respectively.
   5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care as defined in R20-6-1105(D)(1), ~~and~~ (2), ~~R20-6-1105(D)(1)~~ (8), and (9) respectively.
   6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (3), ~~R20-6-1105(D)~~(5), and ~~R20-6-1105(D)~~(8) respectively.
   7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in R20-6-1105(C), the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in R20-6-1105(D)(1) through (3), (5), and (8) respectively.
      a. The annual high deductible plan "F" deductible shall consist of but-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles.
      b. The annual high deductible Plan "F" deductible is $1,500 for 1998 and 1999, and is based on the calendar year. The Secretary shall annually adjust the deductible thereafter to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.
   8. ~~7.~~ No change.
   9. ~~8.~~ No change.
   10. ~~9.~~ No change.

11. ~~10.~~ Standardized Medicare supplement benefit plan "J" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as described in R20-6-1105(D)(1)~~,~~ ~~(2),~~ through (3), (5), and (7) through~~, (8), (9), and~~ (10) respectively.
12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in R6-20-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign county, preventive medical care benefit and at-home recovery benefit as defined in R20-6-1105(D)(1) through (3), (5), and (7) through (10) respectively.
    a. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles.
    b. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

R20-6-1108. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant who submits an application for a policy or certificate before or during the 6 month period beginning with the 1st day of the 1st month in which an individual is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection, without regard to age.

B. An issuer shall not exclude benefits based on a preexisting condition if an applicant:
1. Qualifies under subsection (A),
2. Submits an application during the time period referenced in subsection (A), and
3. As of the date of application, has had a continuous period of creditable coverage of at least 6 months.

C. If an applicant meets the criteria listed in subsection (B) (1) and (2), but has had a continuous period of creditable coverage that is less than 6 months, an issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

D. ~~B.~~ Except as provided in subsections (B) and (C) and R20-6-1119, subsection (A) ~~A~~ shall not be construed as preventing the exclusion of benefits under a policy or certificate, during the 1st 6 months of coverage, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

R20-6-1113. Required Disclosure Provisions

A. No change.
B. No change.
C. No change.
1. No change.
2. No change.
3. The outline of coverage provided to applicants pursuant to this rule consists of 4 parts: a cover page, premium information, disclosure page, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix B in no less than 12-point type. All ~~The standard~~ plans A-J shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and payment frequency shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
4. No change.

D. No change.

R20-6-1121. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue
1. Eligible persons are those individuals described in subsection (B) who apply to enroll under a Medicare supplement policy not later than 63 days after the date of the termination of enrollment described in subsection (B), and who submit evidence of the date of termination or disenrollment with the application for the policy.
2. With respect to eligible persons, an issuer shall not:
    a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (C) that is offered and is available for issuance to new enrollees by the issuer;
    b. Discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; or
    c. Impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons. An eligible person is an individual described in any 1 of paragraphs (1) through (6) below:
1. The individual is enrolled under an employee welfare benefit plan that:
    a. Provides health benefits that supplement the benefits under Medicare, and
    b. Terminates or ceases to provide all such supplemental health benefits to the individual.
2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply:
    a. The organization's or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

b. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

c. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

i. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

ii. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

iii. The individual meets such other exceptional conditions as the Secretary may provide.

3. The individual is:

a. Enrolled with 1 of the following organizations:

i. An eligible organization under a contract under Section 1876 (Medicare risk or cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

iv. An organization under a Medicare Select policy; and

b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (B)(2).

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization;

b. Of other involuntary termination of coverage or enrollment under the policy;

c. The issuer of the policy substantially violated a material provision of the policy; or

d. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

5. The individual meets both of the following conditions:

a. The individual was enrolled under a Medicare supplement policy, terminates that enrollment, and subsequently enrolls, for the 1st time, with:

i. Any Medicare+Choice plan under Part C of Medicare,

ii. Any eligible organization under a contract under Section 1876 (Medicare risk or cost),

iii. Any similar organization operating under demonstration project authority,

iv. An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or

v. A Medicare Select policy; and

b. The enrollee terminates the subsequent enrollment under subsection (B) (5) during any period within the 1st 12 months oft he subsequent enrollment (which the enrollee is allowed to do under section 1851(e) of the federal Social Security Act).

6. The individual, upon 1st becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

C. Products to Which Eligible Persons are Entitled. An eligible person is entitled to the following Medicare supplement policy:

1. Under subsection (B) (1), (2), (3) and (4): a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer;

2. Under subsection (B) (5): the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (C)(1); and

3. Under subsection (B)(6): any Medicare supplement policy offered by any issuer.

D. Notification provisions

1. At the time of an event described in subsection (B) which causes an individual to lose coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) which causes an individual to cease enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Appendix B. Medicare Supplement Coverage Plans

[12 point]

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:

BENEFIT PLAN(s) _____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in Arizona ~~your state~~.

BASIC BENEFITS:	Included in All Plans.
Hospitalization:	Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses:	Part B coinsurance (Generally [20]% of Medicare approved expenses).
Blood:	First 3 pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	~~Basic~~ Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after you have paid a calendar year [$1,500] deductible. Benefits from high deductible plans F and J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and B, but do not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

Appendix B. Medicare Supplement Coverage Plans (*Continued*)

PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.

[for agents] Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:] [insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than 4 plans may be shown on 1 chart. For purposes of illustration, charts for each plan are included in this Article. An issuer may use additional benefit plan designations on these charts pursuant to R20-6-1106.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

Appendix B. Medicare Supplement Coverage Plans - Plan A (*Continued*)

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$0	$[768 ~~764~~] (Part A Deductible)
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~]	$0	Up to $[96.00 ~~95.50~~] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan A (*Continued*)

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan B (*Continued*)

PLAN B
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~]	$0	Up to $[96.00 ~~95.50~~] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan B (*Continued*)

PLAN B
MEDICARE (PART B)-MEDICAL SERVICES- PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan C

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan C (*Continued*)

PLAN C
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) - Plan D

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~](Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan D (*Continued*)

PLAN D
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan E

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~]a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan E

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts* (the Part B Deductible)	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B. Medicare Supplement Coverage Plans - Plan E *(Continued)*

PLAN E

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	OTHER BENEFITS		
*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual ~~Annual~~ physical and preventive tests and services, such as: ~~fecal occult blood test,~~ digital rectal exam, ~~mammogram,~~ hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, ~~influenza shot,~~ tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan F will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan F will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (the Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved			

Amount *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts		80%	20%$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** **PLAN PAYS**	IN ADDITION TO $1500 DEDUCTIBLE** **YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amountsover $50,000 lifetime maximum

Appendix B. Medicare Supplement Coverage Plans - (*Continued*) - Plan G

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) - Plan G

PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*)- Plan H

PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*)- Plan H

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) - Plan I

PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~]a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*)- Plan I

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*)- Plan J

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~]] a day	$[192 ~~191~~]a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			

- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) -Plan J

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts* (the Part B Deductible)	$0	$[100]	$0

Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B. Medicare Supplement Coverage Plans (*Continued*) - Plan J

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
OTHER BENEFITS-NOT COVERED BY MEDICARE			
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual ~~Annual~~ physical and preventive tests and services, such as: ~~fecal occult blood test,~~ digital rectal exam, ~~mammogram,~~ hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, ~~influenza shot,~~ tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Appendix F. Medicare Duplication Disclosure Statements

~~**Medicare Disclosure Statements**~~

MEDICARE DISCLOSURE STATEMENTS
Instructions for use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries

1. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

2. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person who already has a Medicare supplement policy except as a replacement policy.

3. Property/Casualty and Life insurance policies are not considered health insurance.

4. Disability income policies are not considered to provide benefits that duplicate Medicare.

5. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

6. ~~5.~~ The federal law does not preempt state laws that are more stringent than the federal requirements.

7. ~~6.~~ The federal law does not preempt existing state form filing requirements.

8. Section 1882 of the federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix F remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

Appendix F. Medicare Duplication Disclosure Statements ***(Continued)***

[Original disclosure statement for ~~For~~ policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Duplication Disclosure Statements ***(Continued)***

[Original disclosure statement for ~~For~~ policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Duplication Disclosure Statements ***(Continued)***

[Original disclosure statement for ~~For~~ policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for 1 of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Original disclosure statement for ~~For~~ policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for 1 of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Original disclosure statement for ~~For~~ policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements**
(Continued)

~~[For long-term care policies providing both nursing home and non-institutional coverage.]~~

~~IMPORTANT NOTICE TO PERSONS ON MEDICARE~~

~~**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**~~

~~**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**~~

~~Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.~~

- ~~This is long-term care insurance that provides benefits for covered nursing home and home care services.~~
- ~~In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.~~
- ~~This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.~~

~~**Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.**~~

~~**Before You Buy This Insurance**~~

- ~~Check the coverage in **all** health insurance policies you already have.~~
- ~~For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.~~
- ~~For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.~~
- ~~For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.~~

Appendix F. Medicare Disclosure Statements ***(Continued)***
~~[For long-term care policies providing nursing home benefits only.]~~

~~IMPORTANT NOTICE TO PERSONS ON MEDICARE~~

~~**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**~~

~~**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**~~

~~Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.~~

- ~~This insurance provides benefits primarily for covered nursing home services.~~
- ~~In some situations Medicare pays for short periods of skilled nursing home care and hospice care.~~
- ~~This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.~~

~~**Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.**~~

~~**Before You Buy This Insurance**~~

- ~~Check the coverage in **all** health insurance policies you already have.~~
- ~~For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.~~
- ~~For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.~~
- ~~For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.~~

Appendix F. **Medicare Disclosure Statements** ***(Continued)***
~~[For policies providing home care benefits only.]~~

~~IMPORTANT NOTICE TO PERSONS ON MEDICARE~~

~~**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**~~

~~**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**~~

~~Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.~~

- ~~This insurance provides benefits primarily for covered home care services.~~
- ~~In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.~~
- ~~This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.~~

~~**Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.**~~

~~Before You Buy This Insurance~~

- ~~Check the coverage in **all** health insurance policies you already have.~~
- ~~For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.~~
- ~~For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.~~
- ~~For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.~~

Appendix F. **Medicare Disclosure Statements *(Continued)***

[Original disclosure statement for ~~For~~ other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accident injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Alternative disclosure statement for policies that provide benefits for specified limited services]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review *the Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. **Medicare Disclosure Statements** ***(Continued)***

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the policy conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.