NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-16-401	New Section
R9-16-402	Repeal
R9-16-402	New Section
R9-16-403	New Section
R9-16-404	New Section
R9-16-405	New Section
R9-16-406	Repeal
R9-16-406	New Section
R9-16-407	Repeal
R9-16-407	New Section
R9-16-408	Repeal
R9-16-409	Repeal
R9-16-410	Repeal
R9-16-411	Repeal
R9-16-412	Repeal
R9-16-413	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. § 36-136(F)

Implementing statute: A.R.S. § 36-136.01

3. The effective date of the rules:

May 16, 2002

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

Notice of Rulemaking Docket Opening: 7 A.A.R. 3120, July 20, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 5574, December 21, 2001

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

Name: Kathleen Phillips, Rules Administrator

Address: Department of Health Services
1740 W. Adams, Suite 102
Phoenix, AZ 85007

Telephone: (602) 542-1264

Fax: (602) 364-1150

E-mail: kphillips@hs.state.az.us

or

Name: Will Humble, Office Chief

Address: Department of Health Services
3815 N. Black Canyon Highway
Phoenix, AZ 85015

Telephone: (602) 230-5941

Fax: (602) 230-5933

E-mail: whumble@hs.state.az.us

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

The current rules, adopted September 29, 1976, set forth requirements for the registration of sanitarians with the Sanitarians' Council (Council). Proposed rules were drafted and published in the *Arizona Administrative Register* on September 20, 2000; oral proceedings were held, and a final rulemaking package was submitted to the Governor's Regulatory Review Council. In the process of reviewing the final rulemaking package, substantive and statutory issues were identified and the rulemaking was terminated. The Department conducted a five-year review of the rules and the five-year review report was approved by G.R.R.C. on January 8, 2002. These rules address issues in the Report, reflect current industry standards and Council policy, incorporate current statutory requirements, and resolve the issues identified during the G.R.R.C. review.

R9-16-401 is being repealed and replaced with new definitions. R9-16-402 provides an individual with procedures for applying to take the sanitarian examination and registration as a sanitarian. R9-16-403 details how a registered sanitarian renews registration and provides procedures when registration has lapsed. R9-16-404 requires registered sanitarians to notify the Council when there is a change in the registered sanitarian's name or address. R9-16-405 contains licensing time-frame rules established to accommodate the Council's substantive review of applications at the Council's scheduled quarterly meetings. If an application is submitted and determined to be administratively complete two days after a quarterly Council meeting, 118 days will be clocked on the substantive review time-frame before the next Council meeting. In addition, the Council, at a Council meeting, may determine that an application does not comply with the requirements and request further information. If the applicant submits the requested information four to five days after the Council meeting, another 115 days will be clocked on the substantive review time-frame. The substantive review time-frame established in rule does not accommodate the maximum amount of time that could be clocked but does allow the Council to review most applications at the scheduled quarterly meetings. The Council may still have to hold telephonic meetings to comply with the established licensing time-frames if an application is deemed administratively complete immediately after a Council meeting and the applicant submits information immediately after a Council meeting as stated above. R9-16-406 sets forth the authority of a registered sanitarian and R9-16-407 provides criteria and procedures for suspending, denying, or revoking the registration of a registered sanitarian. The remaining sections, R9-16-408 through R9-16-413, are being repealed because the rules exceed the Council's statutory authority or contain material that is not appropriate for rulemaking.

7. Reference to any study that the agency relied on in its evaluation of or justification for the 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

8. 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

9. The summary of the economic, small business, and consumer impact:

The Department will benefit from increasing the sanitarian examination fee for individuals to the actual cost of the sanitarian examination under A.R.S. § 36-136.01. The Department will also incur costs for promulgating the rules and implementing licensing time-frames.

An applicant for sanitarian registration will benefit from the elimination of the prohibition against the applicant's taking the sanitarian examination more than three times within five years. An applicant will have minimally increased costs due to the increase in the sanitarian examination fee. In addition, the proposed rules require individuals previously registered through reciprocity to take the sanitarian examination, which will minimally increase those individuals' costs.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Technical and grammatical changes were made at the suggestion of G.R.R.C. staff.

11. A summary of the principal comments and the agency response to them:

The Department did not receive any comments.

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

None

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously made as an emergency rule?

No

15. The full text of the rules follow:

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

ARTICLE 4. REGISTRATION OF SANITARIANS

Section

R9-16-401. ~~Expired~~ Definitions

In this Article, unless otherwise specified:

1. "Applicant" means an individual requesting from the Council:
   a. Approval to take the sanitarian examination;
   b. Registration as a sanitarian; or
   c. Renewal of registration as a sanitarian.
2. "Application packet" means a Council-approved application form and the documentation necessary to establish an individual's qualifications for registration as a sanitarian.
3. "Billet" means an individual's military job position and job description.
4. "Council" means the Sanitarians' Council established under A.R.S. § 36-136.01(A).
5. "Course" means a program of instruction for which credit toward graduation or certification is given.
6. "Day" means calendar day.
7. "Environmental health" means the well-being of a human as affected or influenced by external conditions such as: bacteria and viruses; transmitted diseases; hygiene; housing; and contamination of food, air, water, or soil.
8. "Full-time military duty" means active duty in any branch of the United States military service.
9. "Natural science" means anatomy, bacteriology, biochemistry, biology, botany, biophysics, biostatistics, cell physiology, chemical engineering, chemistry, ecology, embryology, endocrinology, entomology, environmental health, epidemiology, food bacteriology, dairy sciences, genetics, geophysics, geology, herpetology, histology, hydro geology, hydrology, ichthyology, limnology, microbiology, molecular biology, ornithology, parasitology, pathology, pharmacy, physics, physiology, plant taxonomy, radiological health, sanitary engineering, sewage sanitation, soil science, toxicology, vector control, veterinary science, virology, or zoology or the study of air pollution, community health, environmental diseases, hazardous waste, industrial hygiene, infectious diseases, occupational safety, or public health.
10. "Person" has the same meaning as in A.R.S. § 1-215.
11. "Practice of a registered sanitarian" means acting under the authority of R9-16-406(A).
12. "Registration" means the approval issued by the Council to an applicant who meets the requirements in A.R.S. § 36-136.01 and this Article.
13. "Regulatory authority" has the same meaning as in R9-8-107(B)(11).
14. "Supervise" means to oversee and provide guidance for the accomplishment of a function or activity.

R9-16-402. ~~Definitions~~ Sanitarian Examination and Registration

~~In Article 4, unless the context otherwise requires:~~

~~1. "Continuing education unit" means 10 contact hours of participation in an organized continuing education experience under responsible sponsorship, capable direction and qualified instruction. One contact hour is the equivalent of 50 minutes of classroom study.~~

~~2. "Council" means the Sanitarians' Council established by the Director.~~

~~3. "Department" means the Department of Health Services.~~

~~4. "Director" means Director of the Department.~~

~~5. "Registered sanitarian" means a sanitarian registered in accordance with the provisions of A.R.S. § 36-136.01.~~

~~6. "Sanitarian aide: means a person who performs specific environmental sanitation activities under the supervision of a registered sanitarian pursuant to R9-16-409(B)(6) and R9-16-409(C). A high school education or its equivalent shall be the minimum educational qualifications for the sanitarian aide.~~

~~7. "Sanitarian-in-training" means a person who:~~

~~a. Possesses the necessary education or experience required to become eligible for registration as a sanitarian in Arizona; and~~

~~b. Has submitted evidence that he has been accepted to work in the field of environmental health by a health department, school, government agency or by private industry; and~~

~~c. Has filed an application with the Council for registration as a sanitarian.~~

~~8. "Training agency" means an institution, governmental agency, private business enterprise, or association which conducts a course or program of instruction which will qualify for continuing education credit pursuant to R9-16-413(E).~~

A. The Council shall provide the sanitarian examination at least four times per calendar year.

B. An applicant meeting any one of the requirements in A.R.S. § 36-136.01(F) may sit for the sanitarian examination.

C. At least seven days before a Council meeting, an applicant shall:

1. Submit an application form to the Council that contains:
   a. The applicant's full name and all former names;
   b. The applicant's current address and telephone number;
   c. The applicant's social security number;
   d. If applying under A.R.S. § 36-136.01(F)(1) on the basis of the applicant's employment by a public health agency or private industry in a position directly related to environmental health:
      i. The name of each of the applicant's employers,
      ii. The applicant's position for each employer,
      iii. The months and years of employment in each position, and
      iv. The name and telephone number of each individual who supervised the applicant during five years of employment in environmental health;
   e. If applying under A.R.S. § 36-136.01(F)(2) on the basis of military duty:
      i. Each of the applicant's billets in environmental health,
      ii. The months and years in each billet, and
      iii. The name and telephone number of each individual who supervised the applicant during five years of full-time military duty in environmental health;
   f. If applying under A.R.S. § 36-136.01(F)(3) on the basis of education in natural science:
      i. The name and address of each college or university attended,
      ii. The months and years of attendance,
      iii. Any degree obtained, and
      iv. A listing of courses in natural science completed with a grade of C or better;
   g. Whether the applicant has had an application for a registration, license, or certificate related to the practice of a registered sanitarian denied or rejected by any state or jurisdiction and if so, the:
      i. Reason for denial or rejection,
      ii. Date of the denial or rejection, and
      iii. Name and address of the state or jurisdiction that denied or rejected the application;
   h. Whether the applicant has had a registration, license, or certificate related to the practice of a registered sanitarian suspended or revoked by any state or jurisdiction or entered into a consent agreement with a state or jurisdiction and if so, the:
      i. Reason for the suspension, revocation, or consent agreement;
      ii. Date of the suspension, revocation, or consent agreement; and
      iii. Name and address of the state or jurisdiction that suspended or revoked the registration, license, or certificate or issued the consent agreement;
   i. Whether the applicant has pled guilty to, been convicted of, or entered a plea of no contest to a misdemeanor related to the applicant's employment as a sanitarian or a felony and if so, the:
      i. Felony or misdemeanor charged;

ii. Date of conviction or plea; and
iii. Court having jurisdiction over the felony or misdemeanor;
j. Whether the applicant has been named as a defendant in a malpractice case resulting from the applicant's employment as a sanitarian and if so, an explanation of the circumstances of the malpractice case;
k. The applicant's current employer, including address, job position, and dates of employment, if applicable; and
l. A signed statement by the applicant verifying the truthfulness of the information provided;
2. If applying under A.R.S. § 36-136.01(F)(1), arrange to have a letter provided directly to the Council from each individual who supervised the applicant identifying the dates the individual supervised the applicant for at least five years of employment related to environmental health;
3. If applying under A.R.S. § 36-136.01(F)(2), arrange to have a letter provided directly to the Council from each individual who supervised the applicant identifying the dates the individual supervised the applicant for at least five years of full-time military duty in environmental health;
4. If applying under A.R.S. § 36-136.01(F)(3), arrange to have an official college or university transcript provided directly to the Council from each college or university; and
5. Submit the application fee in A.R.S. § 36-136.01(C).

D. After receiving the written notice of approval in R9-16-405(C)(1)(b), an applicant shall submit to the Council, at least 30 days before the scheduled date of a sanitarian examination, a nonrefundable examination fee of $110 payable to the Treasurer of the state of Arizona.

E. An applicant who does not take a sanitarian examination on the scheduled date shall comply with subsection (D) before taking a subsequent sanitarian examination.

F. An applicant who scores:
1. Seventy percent or more on the sanitarian examination is issued a certificate of registration; or
2. Less than 70%:
a. Fails the sanitarian examination; and
b. Shall meet the requirements in R9-16-402(B), (C) and (D) to sit for the sanitarian examination again.

R9-16-403. ~~Reserved~~ Annual Registration Renewal

A. Except as provided in subsection (B), a registered sanitarian shall submit an application packet for registration renewal on or before December 31st of each year that includes:
1. The applicant's name and current address;
2. Whether the applicant, since the applicant last submitted a registration or registration renewal application in this state:
a. Has had a registration, license, or certificate related to the practice of a registered sanitarian suspended or revoked by any state or jurisdiction or entered into a consent agreement with a state or jurisdiction and if so, the:
i. Reason for the suspension, revocation, or consent agreement;
ii. Date of the suspension, revocation, or consent agreement; and
iii. Name and address of the state or jurisdiction that suspended or revoked the registration, license, or certificate or issued the consent agreement;
b. Has pled guilty to, been convicted of, or entered into a plea of no contest to a misdemeanor that is related to the applicant's employment as a sanitarian or a felony and if so, the:
i. Felony or misdemeanor,
ii. Date of conviction, and
iii. Court having jurisdiction over the felony or misdemeanor; or
c. Has been named as a defendant in a malpractice case resulting from the applicant's employment as a sanitarian and if so, an explanation of the circumstances of the malpractice case;
3. The fee required in A.R.S. § 36-136.01(C); and
4. A signed statement by the applicant verifying the truthfulness of the information provided.

B. A registered sanitarian who does not submit an application packet for renewal registration by December 31 has a grace period until February 15 to submit the applicant packet. If the registered sanitarian does not submit the application packet for renewal registration in subsection (C) during the grace period:
1. The sanitarian's registration expires; and
2. The sanitarian shall, before practicing as a registered sanitarian:
a. Submit for Council approval a new application to take the sanitarian examination and the application fee required in R9-16-402(C)(5),
b. Receive Council approval to take the sanitarian examination,
c. Submit the nonrefundable examination fee required in R-16-402(D), and
d. Pass the sanitarian examination as required in R9-16-402(F)(1).

R9-16-404. ~~Reserved~~ Change of Name or Address

A. A registered sanitarian shall send written notice of a change in the registered sanitarian's name to the Council within 30 days from the date of the change.

B. A registered sanitarian shall send written notice of a change in the registered sanitarian's mailing address to the Council within 30 days from the date of the change.

R9-16-405. ~~Expired~~ Time-frames

A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of approval granted by the Council is set forth in Table 1. The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25% of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Council is specified in Table 1.

1. The administrative completeness review time-frame begins:
   a. For an applicant applying to take the sanitarian examination, when the Council receives the application packet required in R9-16-402;
   b. For an applicant who is approved to take the sanitarian examination, when the applicant takes the sanitarian examination; or
   c. For an applicant applying to renew the applicant's registration as a sanitarian, when the Council receives the application packet required in R9-16-403.
2. If an application packet in subsection (B)(1)(a) or (B)(1)(c) is:
   a. Incomplete, the Council shall provide a deficiency notice to the applicant describing the missing documentation or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Council receives the documentation or information listed in the deficiency notice. An applicant shall submit to the Council the documentation or information listed in the deficiency notice within the time period specified in Table 1 for responding to a deficiency notice.
      i. If the applicant submits the documentation or information listed in the deficiency notice within the time period specified in Table 1, the Council shall provide a written notice of administrative completeness to the applicant.
      ii. If the applicant does not submit the documentation or information listed in the deficiency notice within the time period in Table 1, the Council considers the application withdrawn and shall return the application packet to the applicant; or
   b. Complete, the Council shall provide a notice of administrative completeness to the applicant.
3. If an applicant takes and submits the sanitarian examination in subsection (B)(1)(b) and the examination is:
   a. Incomplete, the Council shall provide a deficiency notice to the applicant stating that the applicant's sanitarian examination is incomplete and identifying the date of the next scheduled sanitarian examination. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the Council receives a completed sanitarian examination; or
   b. Complete, the Council shall provide a written notice of administrative completeness to the applicant.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is specified in Table 1 and begins to run on the date of the notice of administrative completeness.

1. If an application for approval to take the sanitarian examination in subsection (B)(1)(a):
   a. Does not comply with the requirements in this Article, the Council shall provide a comprehensive request for additional information to the applicant.
      i. If the applicant does not submit the additional information within the time specified in Table 1 or the additional information submitted by the applicant does not demonstrate compliance with this Article and A.R.S. § 36-136.01, the Council shall deny approval to take the sanitarian examination and provide the applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A); or
      ii. If the applicant submits the additional information within the time specified in Table 1 and the additional information submitted by the applicant demonstrates compliance with this Article and A.R.S. § 36-136.01, the Council shall provide a written notice of approval to take the sanitarian examination to the applicant; or
   b. Complies with the requirements in this Article and A.R.S. § 36-136.01, the Council shall provide a written notice of approval to take the sanitarian examination to the applicant.
2. If the Council determines that an applicant:
   a. Failed to sit for the sanitarian examination within the time-frame in subsection (F), the Council shall provide a written notice to the applicant requiring the applicant to submit a new application for approval to take the sanitarian examination if the applicant requests registration;
   b. Failed the sanitarian examination, the Council shall deny registration and provide a written notice of appealable agency action that complies with A. R. S. § 41-1092.03(A) to the applicant; or
   c. Passed the sanitarian examination, the Council shall issue a certificate of registration as a sanitarian to the applicant.

3. If an application for renewal of registration as a sanitarian in subsection (B)(1)(c):
   a. Does not comply with the requirements in this Article, the Council shall provide a comprehensive request for additional information to the applicant;
      i. If the applicant does not submit the additional information within the time specified in Table 1 or the additional information submitted does not demonstrate compliance with the requirements in this Article and A.R.S. § 36-136.01, the Council shall deny renewal and provide a written notice of appealable agency action that complies with A.R.S. § 41-1092.03(A) to the applicant; or
      ii. If the applicant submits the additional information within the time specified in Table 1 and the additional information submitted demonstrates compliance with the requirements in this Article and A.R.S. § 36-136.01, the Council shall issue a renewal certificate of registration as a sanitarian to the applicant; or
   b. Complies with the requirements in this Article and A.R.S. § 36-136.01, the Council shall issue a renewal certificate of registration as a sanitarian to the applicant.

D. If an applicant receives a written notice of appealable agency action in subsections (C)(1)(a)(i), (C)(2)(b), or (C)(3)(a)(i), the applicant may file a notice of appeal with the Department within 30 days after receiving the notice of appealable agency action. The appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.

E. If the Council grants approval to take the sanitarian examination or renews a certificate of registration as a sanitarian during the administrative completeness review time-frame, the Council shall not issue a separate written notice of administrative completeness.

F. If an applicant does not sit for the sanitarian examination within 12 months of the Council's approval to take the sanitarian examination, the applicant shall, before taking the sanitarian examination:
1. Submit a new application for Council approval and the application fee required in R9-16-402(C);
2. Receive Council approval to take the sanitarian examination; and
3. Submit the nonrefundable examination fee required in R9-16-402(D).

G. If a time-frame's last day falls on a Saturday, Sunday, or a legal holiday, the Council considers the next business day as the time-frame's last day.

Table 1. Time-frames

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Review Time-frame	Time to Respond to Deficiency Notice	Substantive Review Time-frame	Time to Respond to Comprehensive Written Request
Sanitarian Examination (R9-16-402)	A.R.S. § 36-136.01 (B)	290 days	30 days	60 days	200 days	60 days
Registration (R9-16-402)	A.R.S. § 36-136.01 (B)	90 days	30 days	N/A	60 days	N/A
Annual Registration Renewal (R9-16-403)	A.R.S. § 36-136.01 (C)	180 days	90 days	15 days	90 days	15 days

R9-16-406. ~~Application for Registration~~ Authority of a Registered Sanitarian

~~**A.** Application forms for registration as a registered sanitarian can be obtained from the Department.~~

~~**B.** The application fee and the completed application forms must be received by the Department at least 30 days before the date fixed for the examination or for consideration by the Council when registration without examination is involved.~~

~~**C.** An affirmative vote by at least 3 members of the Council will be required to approve any registration.~~

A. A registered sanitarian may:
1. Act as an authorized representative of a regulatory authority under 9 A.A.C. 8; and
2. Sign inspection reports under 9 A.A.C. 8 and 9 A.A.C. 17.

B. An individual who is not a registered sanitarian shall not approve or disapprove operation of a food establishment under 9 A.A.C 8.

C. An individual who is not a registered sanitarian and who prepares an inspection report under 9 A.A.C. 8 and 9 A.A.C. 17 shall submit the report to a registered sanitarian.

R9-16-407. ~~Fees~~ Denial, Suspension, or Revocation

~~**A.** All fees shall be made payable to the state of Arizona sanitarians Fund.~~

~~**B.** A fee of $40.00 shall accompany each application for initial registration as a sanitarian by examination or reciprocity. Where examination is required, this fee is non-returnable.~~

~~**C.** A fee of $10.00 shall be submitted with a completed application form for the annual renewal of a registration certificate. Annual renewal fees are due and payable on December 1. A published list of registered sanitarians will be issued on February 15. The names of those who have not paid the renewal fee prior to January 1 will be omitted from the published list. Reinstatement after a period of delinquency of 12 months or more shall be subject to the filing of a new application for registration, to the passing of a written examination, and to the payment of the $40.00 application fee.~~

A. The Council may deny, suspend, or revoke a sanitarian's registration if the Council determines that an applicant or a registered sanitarian:

1. Intentionally provided false information on an application or cheated during the sanitarian examination;
2. Pled guilty to, was convicted of, or entered into a plea of no contest to a misdemeanor resulting from employment as a registered sanitarian or a felony;
3. Assisted an individual who is not a registered sanitarian to circumvent the requirements in this Article;
4. Allowed an individual who is not a registered sanitarian to use the registered sanitarian's registration; or
5. Failed to comply with any of the requirements in A.R.S. § 36-136.01 or this Article.

B. In determining whether to deny an applicant's registration or suspend or revoke a sanitarian's registration, the Council shall consider the threat to public health based on:

1. Whether there is repeated non-compliance with statutes or rules,
2. Whether there is a pattern of violations or non-compliance,
3. Type of violation,
4. Severity of violation, and
5. Number of violations.

C. The Council's notice of denial, suspension, or revocation to the applicant or registered sanitarian, notice of hearing, and all hearing procedures shall comply with A.R.S. Title 41, Chapter 6, Article 10.

D. The Council shall provide written notice of a registered sanitarian's denial, suspension, or revocation containing a description of the sanitarian's noncompliance with applicable statutes and rules, by certified mail, to each local health department and each public health service district.

R9-16-408. ~~Examination~~ Repealed

~~**A.** Only persons who meet the requirements set forth in A.R.S. § 36-136.01, subsection (G), shall be eligible for admission to examination for registration as a sanitarian.~~

~~**B.** Examinations for registration as a sanitarian will be administered not less than twice each calendar year, at such times and places in this state as may be specified by the Council. Such examinations will be written and will include such applicable subjects pertinent to the qualifications of a registered sanitarian as the Council may prescribe. The examination papers will not disclose the name of any applicant but will be identified by a number assigned by the Department. The preparation of the examination will be the responsibility of the Council, provided that the Council may at its discretion use material prepared by recognized examination agencies.~~

~~**C.** A person will not be registered if he fails to meet the minimum grade requirements for examination specified by the Council. If an applicant fails to meet such minimum grade requirements in his 1st examination, he may be re-examined at a regularly scheduled examination upon resubmitting his application accompanied by the prescribed fees, provided that no more than 2 re-examinations may be administered to any person in any 4-year period.~~

~~**D.** The examination papers, and records pertaining thereto, will be filed with the Department and retained for at least 4 years.~~

R9-16-409. ~~Registered sanitarian; examples of duties~~ Repealed

~~**A.** There is 1 class of sanitarian for registration purposes. This shall not be construed to prevent further classification by an employer of registered sanitarians for personnel administration purposes. A registered sanitarian may plan, organize, manage, implement and evaluate 1 or more program areas comprising the field of environmental health. Environmental program areas include, but are not limited to: food, beverage, and lodging sanitation; housing, water supply sanitation; land use; solid, liquid and hazardous waste disposal; insect, rodent and vermin control; epidemiology; accident prevention; swimming pool and public bathing facility sanitation; radiation safety; air and water quality; noise pollution; and institutional and industrial hygiene. In performing these activities, a registered sanitarian is involved in sanitation related community education, investigation, consultation, review of construction plans, collecting of samples, interpreting laboratory data, enforcement actions and development of regulations.~~

~~1. All registered sanitarians must be proficient in the following general duties:~~

~~a. Development and execution of 1 or more phases, or 1 or more activities, of an environmental health program.~~

~~b. Performance of responsible environmental health work in a health department, school, government agency or in private industry.~~

~~c. Conduct of investigations of potential environmental health problems and the preparation of suitable recommendations for their solutions.~~

d. ~~Submission of reports of duties performed including evaluations and recommendations for improvement of program.~~

~~2.~~ ~~A registered sanitarian may also:~~

~~a.~~ ~~Prepare and present environmental health information for teaching public health concepts.~~

~~b.~~ ~~Promote improvement in environmental health practice and enforcement of state laws and local ordinances through skillful presentation of facts to the public.~~

~~c.~~ ~~Supervise other registered sanitarians or sanitarian aides.~~

~~**B.**~~ ~~The requirement of A. R. S. § 36-136.01 for registration do not apply to:~~

~~1.~~ ~~Any person teaching lecturing or engaging in research in environmental health but only insofar as such activities are performed for academic purposes.~~

~~2.~~ ~~Any person who is a sanitary engineer, public health engineer, public health engineer assistant or registered professional engineer except when they are working as a sanitarian.~~

~~3.~~ ~~Any public health officer or public health department director pursuant to A. R. S. §§ 36-163 or 36-184.~~

~~4.~~ ~~Any person who holds an Arizona license to practice medicine and surgery or veterinary medicine.~~

~~5.~~ ~~Laboratory personnel when performing or supervising the performance of sanitation related laboratory functions.~~

~~6.~~ ~~Any person employed in environmental sanitation by a state of local governmental agency whose duties are restricted to inspection of 1 of the following:~~

~~a.~~ ~~Air pollution control~~

~~b.~~ ~~Barber shops~~

~~c.~~ ~~Bedding~~

~~d.~~ ~~Bees and honey~~

~~e.~~ ~~Cosmetology shops~~

~~f.~~ ~~Eggs~~

~~g.~~ ~~Foster homes~~

~~h.~~ ~~Grading, sampling and labeling of dairy products~~

~~i.~~ ~~Grain warehouses~~

~~j.~~ ~~Meat~~

~~k.~~ ~~Pesticide applications~~

~~l.~~ ~~Plumbing~~

~~m.~~ ~~Public and semi-public bathing places~~

~~n.~~ ~~Produce~~

~~o.~~ ~~Septic tank installations~~

~~7.~~ ~~A sanitarian-in-training for a period not to exceed 1 year.~~

~~8.~~ ~~This exception does not apply to persons whose duties include a combination of those listed in R9-16-409(B)(6) or 1 of those listed in R9-16-409(B)(6) in combination with other duties related to environmental sanitation.~~

~~**C.**~~ ~~Sanitarian aides and sanitarians-in-training shall be directly supervised by a registered sanitarian in accordance with the following provisions:~~

~~1.~~ ~~No approval or disapproval for operation of a permitted establishment or regulated facility shall be granted.~~

~~2.~~ ~~All inspection reports shall be reviewed and co-signed by a registered sanitarian.~~

~~3.~~ ~~Permission to operate a regulated establishment shall be decided by the registered sanitarian reviewing the inspection reports.~~

R9-16-410. ~~**Denial of application for registration**~~ **Repealed**

~~**A.**~~ ~~The Council may deny an application for registration if the applicant has:~~

~~1.~~ ~~Made a false statement of fact in the application; or~~

~~2.~~ ~~Been convicted of a crime relating to the qualifications or activities as a registered sanitarian, unless clear and convincing evidence of completion of a rehabilitative course of therapy is presented; or~~

~~3.~~ ~~Committed an act of fraud or negligence resulting in a revocation or denial of an application for registration, within the past 3 years, unless clear and convincing evidence of retraining or other appropriate rehabilitation such as community service work is presented; or~~

~~4.~~ ~~Omitted the required information; or~~

~~5.~~ ~~Failed the examination or failed to qualify for the examination; or~~

~~6.~~ ~~Failed to obtain continuing education as required by R9-16-405(B) or R9-16-413.~~

~~**B.**~~ ~~Upon denial of an application for registration under this rule, the Council shall notify the applicant that the application is denied, stating:~~

~~1.~~ ~~The reason(s) for denial; and~~

~~2.~~ ~~That the applicant has the right to a hearing if written request for hearing is filed with Director within the 15 days after service of the notice of denial. Service of notice of denial shall be made by certified mail, return receipt requested, addressed to the applicant at the latest address filed by the applicant in writing with the Council.~~

~~C.~~ ~~The Administrative Procedures Act (A.R.S. § 41-1001 et seq.) and the Department rules of practice and procedures (R9-1-111 et seq.) will govern all hearings required by this Article.~~

R9-16-411. ~~Suspension and revocation of registration~~ Repealed

~~A.~~ ~~The Council may recommend to the Director that disciplinary action be taken against the holder of a certificate or registration who commits any of the following acts:~~
- ~~1. Fraud or misrepresentation in obtaining a certificate, whether in the application or qualification examination;~~
- ~~2. Gross negligence, bribery or incompetence in the practice of the profession;~~
- ~~3. Aiding, abetting or knowingly conspiring with an unregistered person to evade provisions of this Article.~~
- ~~4. Allowing one's registration to be used by an unregistered person or acting as agent, partner, or associate of an unregistered person with intent to evade provisions of this Article.~~
- ~~5. Violating rules of this Article.~~
- ~~6. Committing a crime related to activities as a registered sanitarian.~~

~~B.~~ ~~If a majority of the quorum of the Council find the holder of a certificate or registration has violated any of the provisions of R9-16-411(A), The Council may recommend to the Director, in writing, that the sanitarian be place on probation, or the certificate be suspended or revoked.~~

~~C.~~ ~~The Council will notify the sanitarian of any such disciplinary recommendation by certified mail, return receipt requested, addressed to the sanitarian at the latest address filed by the sanitarian in writing with the Council.~~

~~D.~~ ~~If the Director decides to take disciplinary action against any sanitarian in accordance with the provisions of R9-16-411(B), there shall be a hearing conducted according to the provisions set forth in rule R9-1-101 et seq., unless waived in writing by the sanitarian.~~

~~E.~~ ~~Any orders for probation, suspension, or revocation imposed by the Director shall stipulate all requirements necessary to restore the sanitarian to regular status.~~

~~F.~~ ~~The Director shall immediately notify each county or city health department in the state of the suspension or revocation of a certificate or of the reissuance of a suspended or revoked certificate.~~

~~G.~~ ~~Decisions of the Director shall be subject to judicial review pursuant to A. R. S. Title 12, Chapter 7, Article 6.~~

R9-16-412. ~~Re-registration~~ Repealed

~~A.~~ ~~A sanitarian whose registration has been suspended for a period of time shall automatically be re-registered at termination of the period of suspension if all stipulations in the order of suspension have been met. If the period of suspension extends from 1 calendar year into the next, then the procedure for renewal as described in R9-16-407(C) shall be followed.~~

~~B.~~ ~~A sanitarian who has had his or her registration revoked may apply to the Council for re-registration as a sanitarian. The application shall include substantial evidence that the sanitarian has completed a rehabilitative training course or therapy, or that the basis for revocation has been otherwise removed.~~

R9-16-413. ~~Continuing education~~ Repealed

~~A.~~ ~~Each registered sanitarian must complete at least 1 continuing education unit per calendar year to be eligible to apply for renewal of registration as a sanitarian. A maximum of 1 continuing education unit may be accrued during any 1 calendar year for carryover use during the following calendar year.~~

~~B.~~ ~~The continuing education unit must meet the following minimum criteria in order for credit to be given by the Council:~~
- ~~1. It is a course of study directly related to the responsibilities of a sanitarian in carrying out administrative, educational, investigational or technical duties in the field of environmental health;~~
- ~~2. It must have a specific, written objective(s) which describes expected outcomes for the participant.~~
- ~~3. It must be presented by a college or university accredited by an agency approved by the Council on Post-Secondary Accreditation or by a knowledgeable person(s) who has specialized training and experience in the subject being covered in the program.~~
- ~~4. It must last at least 1 contact hour.~~
- ~~5. It must utilize a mechanism to validate participation. This may include, but is not limited to, earned credits or verification of attendance.~~
- ~~6. It incorporates course evaluation procedures for measuring the effectiveness of the program.~~

~~C.~~ ~~The Council my defer the continuing education requirement to allow certificate holders to practice if the applicant is able to show good cause why the continuing education requirements could not be timely met. The request for deferral must be enclosed with the application for renewal. The deferred contact hours must be completed during the year for which the license is issued. No more than 1 consecutive year of deferred continuing education shall be granted by the Council.~~

~~D.~~ ~~Certificates or other documentation of attendance or completion of continuing education activity must be submitted with each renewal application unless a deferral is requested.~~
- ~~1. A copy of a certificate or other documentation must have the subject or subject matter covered, the date or dates of attendance, the location of the activity, the number of contact hours completed while in attendance and signature of the registrant.~~
- ~~2. It is the responsibility of the registered sanitarian to assure that required evidence of compliance with the continuing education requirements is submitted to the Council on forms provided by the Council.~~

~~3. If a registered sanitarian attends a continuing education course which has not been approved by the Council, the registered sanitarian may request, at the time of registration renewal or before, that the course be approved for continuing education credit. For the Council to consider a request from a registered sanitarian to received continuing education credit, the registered sanitarian must submit documentation to the Council which indicates that the course meets the requirements of this rule.~~

~~4. The Council shall act on all requests for renewal of registration or approval of continuing education courses received from registered sanitarians under this rule within 60 days of receipt.~~

~~E. A training agency may apply to the Council for recognition of its courses as continuing education for registered sanitarians. Eligibility for specific continuing education units or fractions thereof will be determined by the Council in accordance with the criteria set forth in subsection (B).~~

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R20-6-1101	Amend
R20-6-1102	Amend
R20-6-1103	Amend
R20-6-1104	Amend
R20-6-1105	Amend
R20-6-1111	Amend
R20-6-1121	Amend
Appendix B	Amend

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

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

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

3. The effective date of the rules:

May 13, 2002

4. List of all previous notices appearing in the Register addressing the final rules:

Notice of Rulemaking Docket Opening: 7 A.A.R. 4920, October 19, 2001

Notice of Proposed Rulemaking: 8 A.A.R. 47, January 4, 2002

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

Name: Margaret L. McClelland

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

Telephone: (602) 912-8456

Fax: (602) 912-8452

6. An explanation of the rules, including the agency's reasons for initiating the rules:

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

7. A reference to any study that the agency relied on in its evaluation of or justification for the final rules 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

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

None

9. The summary of the economic, small business and consumer impact:

The Department believes that this rulemaking will not greatly impact the economy, small businesses, or consumers because the rulemaking conforms Arizona's Medicare supplement insurance laws with recently adopted federal regulations, and updates the amounts for deductibles and copays for Medicare supplement insurance for 2002. The Department also does not anticipate that the rule changes will economically impact the Department

The benefits of maintaining the performance requirements of the Department and of keeping the rules consistent with the statutes outweigh the cost of the rulemaking.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

The Department did not hold an oral proceeding on this rulemaking and no written or oral comments were received. There are changes made in response to comments from the staff of the Governor's Regulatory Review Council to correct typographical errors, to make the rules more clear, concise, and understandable, and to comply with current rule-writing standards.

11. A summary of the principal comments and the agency response to them:

None

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

None

13. Incorporations by reference and their location in the rules:

None

14. Were the rules previously made as emergency rules?

No

15. The full text of the rules follow:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section
R20-6-1101. Applicability and Scope
R20-6-1102. Definitions
R20-6-1103. Policy Definitions and Terms; Policy Provisions
R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before April 1, 1992
R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992
R20-6-1111. Filing and Approval of Policies and Certificates and Premium Rates
R20-6-1121. Guaranteed Issue for Eligible Persons
Appendix B. Medicare Supplement Coverage Plans

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Applicability and Scope

A. No change
1. No change
2. No change

B. This Article does not apply to a policy or contract of:
1. ~~1~~ One or more employers or labor organizations~~,~~; or ~~of~~
2. ~~the~~ The trustees of a fund established by ~~1~~ one or more employers or labor organizations or combination of employers and labor organizations, for their employees, former employees, or a combination of employees and former employees, or for members, former members, or a combination of members and former members of the labor organizations.

R20-6-1102. Definitions

In this Article, the definitions in A.R.S. §§ 20-102 through 20-105 and the following definitions apply.
1. No change
2. No change
   a. No change
   b. 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. "Creditable coverage" means the type of insurance coverage described in ~~§~~ R20-6-1102.01.
13. No change
14. No change
15. "Home" means any place used by an insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility ~~shall~~ is not ~~be~~ considered the insured's place of residence.
16. No change
17. No change
18. No change
19. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in ~~P.L. 105 33 Title IV, Subtitle A, Ch. 1, § 1859~~ 42 U.S.C. § 1395w-28(b)(1), and includes:
    a. No change
    b. No change
    c. No change
20. No change
21. No change
22. No change
23. No change
24. No change
25. No change
26. No change
27. No change
28. No change

R20-6-1103. Policy Definitions and Terms; Policy Provisions

A. ~~No policy or certificate may be advertised, solicited or issued~~ A person shall not advertise, solicit, or issue for delivery in this state ~~as~~ a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms ~~which~~ that conform to the requirements of this subsection:

1. No change
    a. No change
    b. ~~Such~~ The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or ~~under~~ any motor vehicle no-fault plan, unless prohibited by law.
2. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change
    g. No change
5. No change
6. No change
7. No change
8. No change
9. No change

B. Except for permitted preexisting condition clauses as described in R20-6-1104(B)(1) and R20-6-1105(B)(1) of this Article, ~~no policy or certificate may be advertised, solicited or issued~~ a person shall not advertise, solicit, or issue for delivery in this state a Medicare supplement ~~if such~~ policy or certificate with ~~contains~~ limitations or exclusions on coverage that are more restrictive than those of Medicare.

C. An issuer of a ~~No~~ Medicare supplement policy or certificate shall not ~~may~~ use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

D. An issuer of a ~~No~~ Medicare supplement policy or certificate in force in this state shall ensure that it does not contain benefits that ~~which~~ duplicate benefits provided by Medicare.

R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before April 1, 1992

A. A person shall not advertise, solicit, or issue a ~~No~~ policy or certificate ~~may be advertised, solicited, or issued~~ for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the ~~following~~ minimum standards listed in this Section. These ~~are~~ minimum standards ~~and~~ do not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.

B. No change
1. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
5. No change
6. No change
   a. No change
   b. No change
7. No change
   a. No change
   b. No change
8. No change
9. No change

C. No change
1. No change
2. No change
3. No change
4. No change
5. No change
6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100]; and
7. No change

R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992

A. No change

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.
1. No change
2. No change
3. No change
4. No change
5. No change
   a. No change
   b. No change
6. No change
   a. No change
   b. No change
7. No change
   a. No change
   b. No change
8. No change
9. No change
10. No change
    a. No change

b. A Medicare supplement policy shall provide that benefits and premiums under the policy are suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If the policy is suspended and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

~~b.~~c. Reinstitution of coverage under subsection (B)(10)(a) or (B)(10)(b):

i. No change

ii. No change

iii. No change

C. No change

1. No change
2. No change
3. No change
4. No change
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. No change

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. Preventive medical care benefit: Coverage for the following preventive health services:
   a. No change
   b. Any ~~1~~ one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
      i. ~~Fecal occult blood test or digital~~ Digital rectal examination~~, or both~~;
      ~~ii. Mammogram;~~
      ~~iii.~~ii. No change
      ~~iv.~~iii. No change
      ~~v.~~iv. No change
      ~~vi.~~v. No change
      ~~vii.~~vi. No change
   c. ~~Influenza vaccine administered at any appropriate time during the year and~~ ~~tetanus~~ Tetanus and diphtheria booster every 10 years;
   d. No change
   e. No change
10. No change
    a. No change
       i. No change
       ii. No change
    b. No change
       i. No change
       ii. No change
       iii. No change
       iv. No change
       v. No change
       vi. No change
       vii. No change
       viii. No change
    c. No change
       i. No change

ii. No change
11. No change

R20-6-1111. Filing and Approval of Policies and Certificates and Premium Rates

A. No change
B. No change
C. No change
1. No change
   a. No change
   b. No change
   c. No change
   d. No change
2. No change

D. No change
1. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change

E. Except as provided in ~~the following paragraph of~~ this subsection, the issuer shall combine the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan ~~shall be combined~~ for purposes of the refund or credit calculation prescribed in R20-6-1110. Forms assumed under an assumption re-insurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculations.

R20-6-1121. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue
1. An eligible person is an individual described in subsection (B) who:
   a. ~~Applies to enroll under a Medicare supplement policy not later than 63 days after the date of the termination of enrollment described in subsection (B)~~ Seeks to enroll under a Medicare supplement policy during the period specified in subsection (C), and
   b. Submits evidence of the date of termination or disenrollment with the application for the policy.
2. With respect to an eligible person, an issuer shall not:
   a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (~~C~~E) that is offered and is available for issuance to new enrollees by the issuer;
   b. No change
   c. No change

B. Eligible Person. An eligible person is an individual described in any of the subsections (B)(1) through ~~(6)~~ (B)(7) ~~below~~:
1. No change
   a. No change
   b. No change
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 ~~has been~~ is terminated ~~or the organization terminated or otherwise discontinued providing the plan in the area in which the individual resides~~;
   b. The organization terminates or otherwise discontinues providing the plan in the area where the individual resides;
   ~~b.~~c. No change
   ~~c.~~d. No change
      i. No change
      ii. No change
      iii. No change
3. The individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and any of the conditions listed in subsection (B)(2) apply;
~~3.~~4. The individual is enrolled with an organization listed in this subsection and the enrollment ~~ceased~~ ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (B)(2) or (B)(3):
   a. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost);
   b. No change

c. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
d. No change

~~4.~~5. No change
a. No change
b. No change
c. No change
d. No change

~~5.~~6. The individual meets both of the following conditions:
a. No change
i. Any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare,
ii. Any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost),
iii. No change
iv. Any PACE provider under Section 1894 of the Social Security Act ~~An organization under an agreement, under Section 1833(a)(1)(A) (health care prepayment plan)~~, or
v. No change
b. The individual terminates the subsequent enrollment under subsection (B)~~(5)~~(6) during any period within the 1st 12 months of the subsequent enrollment (which the enrollee is allowed to do under Section 1851(e) of the Social Security Act); or

~~6.~~7. The individual, upon ~~1st~~ first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

C. Guaranteed Issue Time Periods
1. In the case of an eligible person described in subsection (B)(1), the guaranteed issue period:
a. Begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and
b. Ends 63 days after the date of the applicable notice;
2. In the case of an individual described in subsections (B)(2), (B)(3), (B)(4), (B)(6) or (B)(7) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;
3. In the case of an individual described in subsection (B)(5)(a):
a. The guaranteed issue period begins on the earlier of:
i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice, if any, or
ii. The date that the applicable coverage is terminated.
b. The guaranteed issue period ends on the date that is 63 days after the date that coverage terminates;
4. In the case of an individual described in subsections (B)(2), (B)(5)(b), (B)(5)(c), (B)(6) or (B)(7) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 6o days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; and
5. In the case of an individual described in subsection (B) but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after that effective date.

D. Extended Medigap Access for Interrupted Trial Periods
1. In the case of an individual described in subsection (B)(6) (or deemed to be so described under this subsection) whose enrollment with an organization or provider described in subsection (B)(6)(a) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider described in subsection (B)(6)(a), the subsequent enrollment is deemed to be an initial enrollment described in subsection (B)(6).
2. In the case of an individual described in subsection (B)(7) (or deemed to be so described under this subsection) whose enrollment with a plan or in a program described in subsection (B)(7) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program described in subsection (B)(7), the subsequent enrollment is deemed to be an initial enrollment under subsection (B)(7); and
3. For purposes of subsections (B)(6) and (B)(7), an individual's enrollment with an organization or provider described in subsection (B)(6)(a), or with a plan or in a program described in subsection (B)(7) is not considered an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

~~C.~~**E.** Products to Which Eligible Persons Are Entitled. An eligible person is entitled to the following Medicare supplement policy:

1. Under subsections (B)(1) through (B)(~~4~~5): a Medicare supplement policy that has a benefit package classified as Plan A, B, C, or F offered by an insurer;
2. Under subsection (B)(~~5~~6): the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not available, a policy described in subsection (E~~C~~)(1); and
3. Under subsection (B)(~~6~~7): any Medicare supplement policy offered by any insurer.

~~D.~~**E.** No change

1. No change
2. No change

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~~ ten standard ~~plans~~ Plans plus two high deductible ~~plans~~ Plans. This chart shows the benefits included in each ~~plan~~ Plan. Every company must make available Plan "A". Some ~~plans~~ Plans may not be available in ~~Arizona~~ [your state or Arizona].

BASIC BENEFITS: Included in ~~All~~ 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), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First ~~3~~ three 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)	Extended Drugs ($3,000 Limit)
				Preven-tive Care					Preventive Care

* Plans F and J also have an option called a high deductible ~~plan~~ Plan F and a high deductible ~~plan~~ Plan J. These high deductible ~~plan~~ Plans pay the same or offer the same benefits as Plans F and J after you have paid a calendar year [~~$1,500~~ $1,620] deductible. Benefits from high deductible ~~plans~~ Plans F and J will not begin until your out-of-pocket expenses are [~~$1,500~~ $1,620]. 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~~ Parts A and B, but do not include, in ~~plan~~ Plan J, the ~~plan's~~ Plan's separate prescription drug deductible or, in Plans F and J, the ~~plan~~ Plan's separate foreign travel emergency deductible.

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'~~ "Medicare & You" 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~~ Plan prominently identified in the cover page a chart showing the services~~.~~, Medicare payments, ~~plan~~ Plan payments, and insured payments for each ~~plan~~ Plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than ~~4~~ four plans may be shown on ~~1~~ one chart. For purposes of illustration,

charts for each ~~plan~~ Plan are included in this appendix. An issuer may use additional benefit ~~plan~~ 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.]

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$0	$[~~768~~ 812] (Part A Deductible)
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50]	$0	Up to $[~~96.00~~ 101.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the first ~~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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50]	$0	Up to $[~~96.00~~ 101.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

PLAN B

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

No change

PLAN C

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812](Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

PLAN D

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

No change

PLAN E

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the ~~1st~~ first 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~~ Plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [~~$1,500~~ $1,620] deductible. Benefits from the high deductible ~~plan~~ Plan F will not begin until your out-of-pocket expenses are [~~$1,500~~ $1,620]. 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~~ Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~$1500~~ $1620 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~768~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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~~ Plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [~~$1,500~~ $1,620] deductible. Benefits from the high deductible Plan F will not begin until your out-of-pocket expenses are [~~$1,500~~ $1,620]. 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~~ Plan's separate foreign travel emergency deductible.

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO ~~$1500~~ $1620 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~~ three 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 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~~ $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO ~~$1500~~ $1620 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 amounts over $50,000 lifetime maximum

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the ~~1st~~ first 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~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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

No change

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

* A benefit period begins on the first ~~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 ~~plan~~ pays the same or offers the same benefits as Plan J after you have paid a calendar year [~~$1,500~~ $1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [~~$1,500~~ $1,620]. 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~~ Plan's separate prescription drug deductible or the ~~plan's~~ Plan's separate foreign travel emergency deductible.

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO ~~$1500~~ $1620 DEDUCTIBLE** YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~768~~ 812]	$[~~768~~ 812] (Part A Deductible)	$0
61st thru 90th day	All but $[~~192~~ 203] a day	$[~~192~~ 203] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[~~384~~ 406] a day	$[~~384~~ 406] 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~~ three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[~~96.00~~ 101.50] a day	Up to $[~~96.00~~ 101.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First ~~3~~ three pints	$0	~~3~~ three 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

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~~ Plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [~~$1,500~~ $1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [~~$1,500~~ $1,620] 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~~ Plan's separate prescription drug deductible or the ~~plan's~~ Plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~$1500~~ $1620 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~~ three 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

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

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO ~~$1500~~ $1620 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~~ eight weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed ~~7~~ seven each week	
- Calendar year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY ~~$1500~~ $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO ~~$1500~~ $1620 DEDUCTIBLE** YOU PAY**
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 physical and preventive tests and services, such as: digital rectal exam, hearing			

screening, dipstick urinalysis, diabetes screening, thyroid function test, 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

SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**

OTHER BENEFITS (*Continued*)

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the ~~1st~~ first 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*.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Article 20	New Article
R20-6-2001	New Section
R20-6-2002	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. § 20-167(H)

Implementing statutes: A.R.S. §§ 20-167(H), 20-1098.01(G), and 20-1098.06

3. The effective date of the rules:

The rule will become effective on July 1, 2002, the date on which the authorizing statute becomes effective.

4. List all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 7 A.A.R. 5265, November 23, 2001

Notice of Proposed Rulemaking: 8 A.A.R. 256, January 11, 2002

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

Name: Vista Thompson Brown or Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th Street, 2nd Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

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

Laws 2001, Chapter 327 established a captive insurance program. Effective July 1, 2002, the legislation requires the Director of the Department of Insurance to establish fees for the issuance and renewal of a captive insurer license. This rule will establish those fees. This rule also cross-references A.R.S. § 20-1098.06 that establishes the captive insurer's obligation to pay any examination costs.

7. A reference to any study that the agency relied on in its evaluation of or justification for the final 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

8. 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

9. The summary of the economic, small business and consumer impact:

There will be economic impacts to captive insurers as a result of this rule due to the fees imposed. Because captive insurers are typically established only by large enterprises that would otherwise be capable of self-insuring their risks and are not subject to any premium taxes as are regular insurers, the economic impact is estimated to be minimal.

There will be a minimal economic impact on the Department, the Secretary of State, and the Governor's Regulatory Review Council (Council) for costs associated with the rulemaking process.

10. A description of the changes between the proposed rules, including supplemental notices and final rules (if applicable):

Grammatical and organizational changes suggested by Council staff were made.

11. A summary of the principal comments and the agency response to them:

No comments, either oral or written, were received.

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

13. Incorporations by reference and their location in the rule:
None

14. Was this rule previously made as an emergency rule?
No

15. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 20. CAPTIVE INSURERS

Section
R20-6-2001. Reserved
R20-6-2002. Fees; Examination Costs

ARTICLE 20. CAPTIVE INSURERS

R20-6-2001. Reserved.

R20-6-2002. Fees; Examination Costs

A. A corporation applying for a license to do business as a captive insurer, as defined in A.R.S. § 20-1098(4), shall pay a nonrefundable fee of $1,000.00 to the Department for issuance of the license. The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.

B. A captive insurer shall pay a nonrefundable annual renewal fee of $5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.01(G).

C. In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination conducted by the Director, in accordance with A.R.S. § 20-1098.06.